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New Syllabus For Scotland

THE General Nursing Council for Scotland has now introduced revised syllabuses for all parts of the Register and these come into force on May 1. These new syllabuses are of general interest in that the new ones of the General Nursing Council for England and Wales came into force on January 1 this year, and there is reciprocal registration between the three statutory bodies of the United Kingdom and indeed considerable interchange throughout the kingdom between trained nurses and between sister tutors who prepare the candidates for the three different examinations.

The trends towards studying the care of the whole person and the emphasis on health and the prevention of sickness before concentrating on nursing care in disease are well shown in the Scottish syllabus. Indeed in the preliminary examination, the First Part now deals with: Section I. Elementary Anatomy and Physiology (one subject) and Section II. Health and Nutrition. In England and Wales this latter section is entitled 'Personal and Communal Health' and although the details are very similar there are some small points of difference. In the Scottish syllabus the introduction to this section requires: "A brief survey of the National Health Service; the aims and functions of the Public Health Services in the endeavour to preserve the health of the individual and the community; the place of the nurse in the health programme." Also, nutrition and cookery are placed together, whereas in the English syllabus nutrition is found under anatomy and physiology. Infection and micro-organisms appear, in the Scottish syllabus, in the First Part, under Section II, Relationship of Environment to Health, whereas they do not appear, in the English syllabus, until Part 2, with Principles and Practice of Nursing.

In the Second Part of the preliminary syllabus the subjects are: Principles and Practice of Nursing (Part I—Part II being the final examination) and First Aid. In the former, standards of ethical conduct, an outline of nursing tradition and history and the study of human relationships are included, in addition to the usual nursing procedures.

In the Scottish syllabus no reference is made to 'psychology applied to nursing' which appears under the principles and practice of nursing in Part II of the English preliminary examination syllabus. The development of the normal child is referred to under Paediatrics for the final examination syllabus (as it is in the English) but there is, apparently, no reference to the now recognized essential basis of good mental health—the mother-child and family relationships. The tutor can perhaps introduce this under the subject Human Relationships, which includes "the patient as an individual; the interpretation of the patient's reaction to illness with sympathy and understanding; differences due to social background and age; the attitude of the nurse to the patient's relatives and friends; the place of the nurse in the hospital team; and relationship to fellow-workers in all departments". It will certainly be interesting to see whether these rather abstract subjects will appear among the questions in future examination papers.

In the syllabus for the final general examination the subjects listed are closely similar to the English syllabus, giving perhaps more detail—and still requiring cupping and leeching; a section on gynaecological and obstetric emergencies is included for male student nurses. There is also a heading 'The Nurse and the Law' but no further guidance or detail is given on this important subject.

The final Section, XI. Social Aspects of Disease, requires a knowledge of: "factors contributing to ill-health; professional relationship and co-operation with all the departments of the hospital, the social worker within the hospital, and the Local Health Service; an introduction to, and the importance of, the work of the nurse in the public health field; and an outline of available social services."

The recent discussions at the St. Andrews Conference for trained nurses in all types of work in Scotland, on the presentation to the student nurse of other aspects of nursing care such as domiciliary and public health work, will, no doubt, be of practical help in the development of this section of the syllabus, following or diverging from the methods already in practice south of the Border. It would be interesting to know whether any experimental schemes have yet been introduced.

The General Nursing Council for Scotland has prepared a *Guide to the Syllabus* to provide tutors and lecturers with "some indication of the details and depth of teaching desirable". The Guide, in each case, is concise, clear and definite and should be of great importance as it is in the 'detail and depth of teaching' that controversy does, and will no doubt always, lie. The following extracts will be of interest:

> INTRODUCTION . . . the Council wish to emphasise that the theoretical instruction required for the Preliminary Examination should be presented to the student nurse in a simple manner, and therefore reiterate the opinion that the temptation to include all the theoretical teaching required for the Prelimination Examination in the preliminary training school period should be strongly resisted. The Council recommend

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that a Block System or Study Day System should be adopted . . . the value of [either] lies largely in the consequent freedom in planning the class-time and in correlating theory with practice by a greater use of the available teaching and other visits. . . . the students are likely to be much more receptive than can reasonably be expected when the class hour has to be fitted into an already full day or before or after a span of night duty.

ELEMENTARY ANATOMY AND PHYSIOLOGY . . . It is important for an intelligent understanding of the structure and functions of the human body that the student be taught to consider the body as an integrated whole, as a living and dynamic organism. The objective should be the correlation of anatomy and physiology, i.e. structure as designed for function.

HEALTH AND NUTRITION . . . it is hoped that the new grouping will help to put the subjects included under this heading into proper perspective. . . . The field of communal health can be closely linked with social standards and the effects of environment on health, and here is an opportunity to arouse interest in preventive measures and social medicine from the very beginning.

FINAL EXAMINATION SYLLABUS: . . . The Council are of the opinion that no nurse should be responsible for this procedure [giving of intramuscular injections] until she has passed the Preliminary Examination and has completed the course of instruction in Principles and Practice of Nursing, Part II, and has had adequate supervised practice.

SECTIONS VI, VII, VIII, IX, X, XI: . . . the student nurse should be encouraged to view the patient as a normal human being who has become sick, but who still requires to be regarded as a whole person, not just a 'specific type of illness'. It is suggested, therefore, that the teaching staff of the School of Nursing should, with the medical and specialist lecturers, analyse the content of the class room teaching with a view to deciding what is the core of essential knowledge in each field which needs to be presented in the available hours of class teaching. The Health Service should be regarded as a whole, inter-relating the care given to the individual by all who participate, the General Practitioner, the Public Health Service and the Hospitals.

Finally, the General Nursing Council for Scotland has drawn up lists of 'lectures, clinical lectures, clinical classes and demonstrations covering the subjects for each examination'. For the preliminary part, 40 class hours are recommended as the minimum required in Elementary Anatomy and Physiology and 30 class hours in Health and Nutrition, which may be given by a registered nurse tutor or a registered medical practitioner comparable to a registrar. For the final examination in addition to the 36 class hours in nursing, the 20 in medical, 20 in surgical nursing and several in each specialty (of which 75 per cent. of each must have been attended), 2 class hours are allotted to Social Aspects of Disease to be given by the almoner or social worker within the hospital *and* an experienced public health nurse.

The *Record of Practical Instruction and Experience* includes an impressive and detailed list of techniques to be practised and signed up, when proficient, by the sister. This neat blue booklet of 23 pages must be taken by the nurse to the practical examinations of the Council. This should ensure careful practical supervision and tuition by the ward sisters and places the true emphasis on the clinical skill of the nurse, and on the ward sister the responsibility for her practical tuition. The syllabus as a whole presents, too, a challenge to the Scottish sister tutors and to all who are responsible for preparing the tutors of the future.

TOPICAL NOTES

Meeting at Worthing—

WELCOMING some 40 members of the Public Health Section of the Royal College of Nursing to the quarterly meeting held in the Court Room of the Town Hall, Worthing, on Saturday morning, April 24, Miss E. M. Wearn, chairman of the Central Sectional Committee, remarked how pleasant was a breath of sea air after the end of winter, and Miss L. J. Ottley, President of the College, paid compliment to the lovely arrangement of spring flowers and foliage decorating the platform. During the latter part of the business meeting there was a valuable discussion on points relating to the future training of the district nurse. The chairman said these would be taken into consideration when preparing material to be submitted by the Royal College of Nursing to the Government Working Party which has this subject under review and of which Miss M. F. Carpenter, Director in the Education Department, Royal College of Nursing, is a member. At the luncheon about 100 members, with the speakers at the afternoon conference, were joined by the Mayor and Mayoress of Worthing, Councillor and Mrs. R. A. Mitchell.

A group at Worthing: seated, left to right, Mrs. A. A. Woodman, M.B.E., Miss L. J. Ottley, Miss Gwen Padfield. Behind, left to right, Miss J. Day, Mrs. G. H. Pringle, Miss Rita Watson, Dr. J. Beynon, Mrs. M. Ayliffe, Miss A. C. Arbon, chairman, Public Health Section within the Worthing Branch, Miss A. I. Coward, Dr. G. H. Pringle, Miss E. M. Wearn, Miss G. Riches, Miss G. Carter, hon. secretary, Public Health Section within the Worthing Branch.

—The Public Health Team

DR. G. H. PRINGLE, medical officer of health for Worthing, presided at the afternoon's open conference on *The Family Doctor and the Public Health Nursing Team*, for which an audience of about 150 filled the Central Clinic, Stoke Abbott Road, Worthing, to capacity. The Mayor of Worthing said with what pleasure he had listened to Miss Ottley's delightful address at the luncheon; his own interest in public health work was enhanced by the fact that his daughter, who had trained at the Westminster Hospital, was at present taking the health visitor course in London. The three excellent addresses which followed were heard with close attention, the speakers being Dr. J. Stanley Thomas, M.R.C.S., L.R.C.P., J.P., general practitioner, East Ham; Miss Gwen Padfield, S.R.N., S.C.M., H.V. Cert., sister-in-charge, William Budd Health Centre, Bristol; and Miss Rita Watson, S.R.N., Queen's Nurse, M.T.D., H.V. Tutor Cert., deputy education officer, Queen's Institute of District Nursing. The discussion was opened by Dr. John Beynon, who as a general practitioner in Brighton had been responsible for calling together there representatives of the local health authority and of the local branch of the British Medical Association to discuss closer co-operation between general practitioners and health visitors, in accordance with the resolution passed at the annual meeting of the British Medical Association in Cardiff last year. The afternoon concluded with a delightful tea party in the Sun Parlour The meetings will be fully reported later.

Mrs. E. O. Jackson, R.R.C.

NEWS OF THE DEATH of Mrs. Edith Olive Jackson, which occurred at University College Hospital on Friday, April 23, will have come as a great shock to her many friends and

admirers in the nursing profession. Mrs. Jackson had been a patient for only a short time in the hospital of which she was so well-known as matron from 1939 to 1950. She gave loyal service to her profession as a member of the Royal College of Nursing having served on the Council of the College for many years, and through her work in the Association of Hospital Matrons. Mrs. Jackson trained at King's College Hospital and before her appointment to University College Hospital was matron of the Norfolk and Norwich Hospital from 1926. The Royal Red Cross was awarded to her for her services in connection with the wartime nursing arrangements in hospitals in north west London and the Home Counties and for her services as principal matron of the Territorial Army Nursing Services. After her retirement in 1950 she continued to be extremely active in professional matters and had been president of the Association of Hospital Matrons and vice-chairman of the Northern Group Hospital Management Committee, London. Details of a memorial service will be found on page 489.

Convalescent Homes Conference

DURING A TWO-DAY convalescent homes conference held under the auspices of the King Edward's Hospital Fund for London at Queen Elizabeth College, on April 23 and 24, delegates heard a talk on *Planned Convalescence* by Dr. F. S. Cooksey, O.B.E., M.D., M.R.C.P., Director, Department of Physical Medicine, King's College Hospital, and on *Occupational Therapy in Rehabilitation and Convalescence* by Miss G. McCaul, M.A.O.T., Head Occupational Therapist, King's College Hospital. In spite of the advance of medical science and the resultant earlier discharge of patients from hospital, Dr. Cooksey said, the continuing need of convalescence was recognized; if hospital beds were to be cleared quickly, planned convalescence was necessary; a regime was needed to ensure that the 'will to recover' was engendered—also realistic workshops. It was important to help the disabled person to overcome his disability and become independent. Miss McCaul described how convalescent patients at King's College Hospital were assessed for work capacity and 'work mindedness', and gradually fitted to resume their place in everyday life; she discussed the various simple, inexpensive fittings and arrangements designed to help the disabled to wash and dress themselves and look after their homes, and remarked that a surprising number of such patients had been taught to help themselves.

Commemoration Day Emblem

ON WEDNESDAY, MAY 12, a Thanksgiving Service at St. Paul's Cathedral, and services in churches all over the country, will commemorate the centenary of the work of Florence Nightingale and her nurses in the Crimean War. A blue and yellow emblem is on sale, to be worn on this day, and the proceeds and the collections at the services will be devoted to the permanent memorial—the endowment of Florence Nightingale House for international nurses studying in this country—which is maintained by the National Florence Nightingale Memorial Committee of Great Britain and Northern Ireland. Application for emblems, price 1s. each (available in packets of 100), should be made to Miss F. Rowe, Executive Secretary, National Council of Nurses of Great Britain and Northern Ireland, 17 Portland Place, London, W.1.

The emblem to be worn on May 12.

The Marion Agnes Gullan Trophy Contest

THE winner this year in the 'true art of nursing' contest for the Marion Agnes Gullan Trophy is St. George's Hospital; the runner-up was King's College Hospital, last year's winner; while the other two hospitals who reached the final contest were Stracathro Hospital, Brechin, and Mapperley Hospital, Nottingham. This was the first year that tutors, being members of organizations affiliated to the Royal College of Nursing, were permitted to enter teams and for the first time a mental hospital entered and reached the final contest, being among the top four of the 27 hospitals competing in the preliminary literary contest.

The practical contest took place at Guy's Hospital on Saturday, April 24, and an intent audience, mainly of student nurses and tutors from many hospitals, watched as the four junior and four senior teams, each of three student nurses, dealt with the situation given them.

The juniors had to handle the medical ward emergency of a convalescent gastric ulcer patient having a slight haematemesis while in the bathroom. The seniors were to prepare for and receive into the ward a patient admitted, through the casualty department, with severe burns of the back. The junior teams were careful, gentle and thoughtful but it is easier to demonstrate busy hands rather than the thinking mind in such a situation and the students evidently found it difficult for all three to appear busy throughout the alloted 15 minutes; it is strange how inadequate a nurse, with a vomiting patient (supplied by the Casualties Union), appears if she has no receiver—however sympathetic her mien.

The senior teams found much to do, but were less successful in their preparations and in the handling of the burnt patient, while other points in such special care were referred to by one of the judges later, who is a sister in a burns unit. It was a pity that these general situations did not give full opportunity for the student nurses from the mental hospital to show their particular art and skill.

The judges were Miss L. E. Snelson, tutor, Royal Southern Hospital, Liverpool and Miss R. Tanner, ward sister, Guy's Hospital, for the senior teams; and for the junior teams, Miss K. M. Crane, sister tutor, St. Thomas' Hospital, and Miss C. Gatt, ward sister, Royal Infirmary, Aberdeen.

After the pleasant tea party in the Nurses' Home, Miss Addison, matron, Guy's Hospital, as hostess, announced the judges' award and Miss Gullan herself presented the beautiful trophy, the replica being held by the winning hospital for a year. Miss Gullan, in her inimitable way, congratulated the competitors on their good effort—but reminded them, from her 50 years of experience, that even when they had reached a standard of safe care for their patients, they still had to teach themselves the real art of nursing; so observing and feeling with each particular patient that they could fulfil that patient's desires and needs, making her feel at once secure and confident so that she could help herself to recover.

The St. George's Hospital teams and the Marion Agnes Gullan trophy, with Miss Gullan (left), Miss M. B. Powell, matron, behind, and Miss O. Walden-Jones, sister tutor.

Nutrition—Old and New

V. MINERAL DEFICIENCIES AND EXCESSES

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IN the human body there are at least 13 different mineral elements which are known to be essential for life. They are sodium, potassium, calcium, magnesium, iron, copper, zinc, manganese, cobalt, phosphorus, sulphur, chlorine and iodine. Fluorine is also important, but may not be absolutely essential. No two minerals have the same distribution within the body, and each has its own particular function which cannot be performed by any of the others. These minerals vary also in the ease with which they are absorbed and the way in which they are excreted, and whether they are stored in the body or not.

Some elements perform their function in the body mainly in simple inorganic solution, for example, sodium and chlorine, while others form an essential part of vitally important organic compounds, for example, iron in the pigment haemoglobin, iodine in the hormone thyroxin, zinc in the enzyme carbonic anhydrase and cobalt in vitamin B_{12}. It is clearly impossible in one short article to discuss adequately all 13 mineral elements. The alternatives are either to say a few words about each of them or to deal with two or three in more detail. The latter alternative has been chosen and the elements that will be considered are sodium (and with it chlorine), potassium, calcium and iron. Deficiencies and excesses of these minerals are of far greater clinical importance than deficiencies of, say, magnesium and zinc which have not so far been discovered to occur in human beings at all.

Absorption and Excretion

To be absorbed an element must be in solution, and for this reason it is, generally speaking, the most soluble ones that are most readily absorbed. On the other hand, it is the least soluble ones that are most readily stored. The monovalent elements, sodium, potassium and chlorine, are all absorbed to the extent of about 90 per cent. of the intake; they are all freely excreted by the kidney, and this is the organ which regulates the amount of them to be retained within the body.

The divalent metals, calcium and magnesium, are absorbed with more difficulty; about one-third of the calcium and half the magnesium in the food are absorbed, and a corresponding amount excreted in the urine. The remainder passes through the digestive tract unabsorbed and is excreted in the faeces.

The body has very little power to excrete iron, and the amount in it is regulated by controlled absorption. Under normal conditions an adult absorbs only about one four-hundredth of the amount of iron in his food. The intestine can be forced to absorb iron by giving large doses of iron salts, but once this iron is absorbed it is stored away in the liver and spleen and possibly also in the bone marrow. If a person continues to take iron salts in large amounts he can easily double the normal amount of iron in his whole body.

Enormous quantities of digestive juices (of the order of 8 litres) are poured into the gut every day. These solutions are all isotonic with the plasma and contain sodium chloride, and smaller amounts of potassium, calcium, magnesium and other elements. It is obvious that secretion into the gut at this rate is only possible because there is an equally rapid reabsorption lower down; the amounts of sodium and chloride in the diet are only a fraction of the amounts absorbed by the intestine, and the continuous loss of any one of the gastro-intestinal fluids must have very serious consequences because of the losses of water and of salts which it entails.

Distribution of Minerals in the Body

Before considering when there may be too much or too little of the different mineral elements within the body, a word must be said about the normal quantities and their distribution. The accompanying table gives an idea of the amounts one may expect the body of a 10 stone adult to contain, but it must be emphasized that quantity is no guide to importance. A person could not survive without his 0.02 grams of iodine any more than he could without his 1,240 grams of calcium.

Distribution and Approximate Amounts of Minerals in the Body of an Adult weighing 10 stone

All the quantities are given in grams

Mineral	*Amount in whole body*	*Distribution*
Sodium ...	120	Extracellular fluids, gastro-intestinal secretions and bones.
Potassium ...	150	97% in the cells. 3% in the extracellular fluids.
Calcium ...	1,240	Bones and teeth. About 1 gram in the extracellular fluids.
Magnesium ...	25	Bones. Cells and extracellular fluids.
Iron	4	In the haemoglobin of the red blood cells and the myoglobin of muscle. Stored in the liver, spleen and bone marrow.
Copper ...	0.1	Cells and extracellular fluids. Stored in the liver.
Zinc	1.5	Hair and nails. Part of the enzyme carbonic anhydrase in the red blood cells, stomach and pancreas. Stored in the liver.
Manganese ...	?	Distributed throughout the body, but concentrated in the liver, pancreas and hair.
Cobalt ...	?	In vitamin B_{12} in the liver.
Phosphorus ...	730	Bones and teeth and cells.
Sulphur ...	110	As part of the amino acids cystine and methionine in the proteins of the cells and plasma, and of the hair and nails.
Chlorine ...	84	Extracellular fluids. Gastro-intestinal secretions.
Iodine ...	0.02	Half the total in the thyroid gland and half distributed through the rest of the body.
Fluorine ...	?	Bones and teeth.

Sodium, Chlorine and Potassium

It is convenient to consider sodium, chlorine and potassium together since they are all intimately connected with the water balance and acid-base equilibrium of the body. Sodium is the base of the extra-cellular fluids, the plasma, lymph, cerebro-spinal fluid and interstitial fluid, whereas potassium is the base of the fluid inside the cells. The separation is effected by the metabolic activity of the cells, and once this is destroyed minerals and water begin to stream across the membranes lining the cells. Controlled exchange is the basis of muscular and nervous activity.

Chlorine is also an extracellular mineral, but there is

relatively more sodium than chloride in the plasma, about one third of the sodium being combined with bicarbonate. Sodium bicarbonate is the salt which makes the pancreatic juice alkaline, and chloride combined with hydrogen is the acid in the gastric juice. About a third of the sodium in the body is in the bones.

Most of the sodium and chloride that we eat comes from the common salt which we add to our food, whereas the potassium is derived from the food itself. We add sodium chloride because of its flavouring value, and only foods of animal origin, meat, fish, milk and eggs, contain significant amounts of sodium and chloride. Plant foods contain only traces. Potassium is uniformly distributed in natural foodstuffs, so that it is much more difficult to design a diet which is low in potassium than one which is low in sodium.

Deficiency of Sodium Chloride

A deficiency of sodium chloride may arise whenever there is a forced loss of any of the body fluids. If this is brought about by sweating, and particularly if the person is not able to drink, his signs and symptoms will be those of dehydration because he will almost certainly have lost more water than salt, and his plasma will have a normal or even high concentration of sodium and chloride in it. Symptoms of salt deficiency appear if he is able to take water and dilute his extracellular fluids so that the concentration of sodium in them is reduced. This is what happens to stokers, miners and others who work in hot atmospheres and lose a great deal of sweat. It also happens to anyone who is losing gastric or intestinal secretions by vomiting or diarrhoea, and who is able to take only water by mouth. The secretions entering the small bowel contain sodium chloride and sodium bicarbonate, so that they are alkaline, and their loss may leave the body with an excess of acid radicles inside it, as well as a deficiency of salt and water. Vomiting, on the other hand, generally means a loss of hydrochloric acid as well as of sodium chloride, so that an alkalosis within the body is the result.

If there is no gastro-intestinal disturbance or excessive sweating, sodium and chloride are excreted almost entirely in the urine. But the function of the kidney is to preserve the volume and composition of the body fluids. This function of preserving is quite as important as the function of excreting. Hormones produced by the adrenal cortex appear to be responsible, in part at any rate, for the final reabsorption of sodium from the renal tubules, and in Addison's disease, in which there is a destruction of the adrenal cortex, sodium and chloride are not reabsorbed as they should be, but allowed to escape in the urine. This leads to a decrease in the concentration of sodium and chloride in the plasma, that is to salt deficiency.

Our knowledge of the fundamental changes which go on in the body in a state of sodium deficiency has been gained largely by reproducing the deficiency in healthy persons. Twenty years ago the importance of sodium chloride deficiency in clinical medicine was realized, but patients with salt deficiency generally also suffered from a forced loss of water, alkalosis, acidosis, starvation or adrenal insufficiency so that it was very difficult to disentangle the effects of the one and the other.

In 1936 Professor McCance set out to reproduce experimentally uncomplicated salt deficiency. He used himself as his first experimental animal and he deprived his body of sodium chloride by forced sweating for two hours every day in a radiant heat bath and by living on a diet which was virtually sodium free. He replaced his water loss by drinking. After a week he had lost 17.5 grams of sodium, about 15 per cent. of the amount originally present in his body. By this time he looked and felt an ill man. In his own words "We have all suffered from excessive fatigue and a general sense of exhaustion . . . I noticed it particularly in going up the two flights of stairs to the laboratory, and the effort was accompanied by a sense of breathlessness and a most unpleasant feeling of constriction across my sternum, which compelled me to pause and rest several times on the way up." Cramps were a very noticeable symptom, as also was mental apathy. The signs and symptoms were very like those of Addison's disease, but there was no pigmentation or fall of blood pressure.

Excess of Sodium Chloride

A sure sign that there is an excess of sodium chloride inside the body is the appearance of oedema, because all such collections of 'pitting' fluid are extracellular and contain sodium chloride in the same concentration as the plasma. Even when there is a great increase in the volume of the extracellular fluids, however, and hence an absolute excess of sodium chloride in the body, the concentration of sodium and chloride in these fluids and in the plasma is normal. In salt deficiency, on the other hand, there is a decrease in the volume of the extracellular fluids, but this is accompanied by a fall in the concentration of sodium in them.

Potassium Deficiency

A deficiency of potassium may arise from an inadequate intake, as in patients being fed parenterally, or from excessive loss of gastro-intestinal secretion in vomiting or diarrhoea, or drainage from fistulae, or it may be caused by an excessive excretion of potassium by the kidney. Diabetic coma, for example, may lead to a deficiency of potassium because of the vomiting and an increased excretion by the kidney, but signs may be latent till they are unmasked by treatment with insulin, which creates a demand for potassium, and the patient may be treated with parenteral fluids which contain no potassium at all.

Although 97 per cent. of the potassium in the body is inside the cells, the remaining 3 per cent., which circulates in the extracellular fluids, is of vital importance in regulating the rhythmic beating of the heart and in maintaining the proper balance between neuromuscular irritability and paralysis. In a rare metabolic disease known as 'familial periodic paralysis', which is hereditary, the concentration of potassium in the serum falls to very low levels and the sufferer then has attacks of weakness and paralysis; these are relieved by the administration of potassium salts. The level of potassium in the serum is partly controlled by the activity of the suprarenal cortex, and if this function fails, as in Addison's disease, the serum potassium may rise to high levels. Low potassium diets are therefore sometimes prescribed for this disease, and the giving of potassium salts to such patients may be very dangerous.

It is only within the past three or four years that potassium deficiencies have been studied experimentally, and the reason for this is, firstly, that it is impossible to devise diets composed of ordinary foods which are low in potassium, and secondly, because there was no ready way of depleting the body of potassium as there was of sodium by sweating. The introduction of 'ion exchange resins', which can take up potassium as well as other minerals, has altered this, and in 1952 two groups of investigators, Drs. Black and Milne in Manchester and Drs. Fourman and Ainley Walker in Oxford, published the results of their experiments on potassium deficiency.

All four had used themselves as their own guinea pigs. Drs. Black and Milne lived on 3 litres of milk a day, which they shook up with resin beforehand, and 125 grams of glucose. The resin removed the potassium from the milk, and in this way they managed to achieve a diet which was almost potassium-free. In course of time they became potassium deficient because they continued to excrete the mineral in the urine. Drs. Fourman and Ainley Walker ate a more ordinary diet, but took 60-90 grams of resin a day with it. This was a more effective method of creating a deficiency because the resin not only removed potassium from the food, but prevented the reabsorption of some of the potassium in the gastro-intestinal secretions.

After about a fortnight they had deprived their bodies of a quarter of the normal amount of potassium in them. They were able to make valuable observations on the mineral exchanges within the body which accompanied this loss. Their symptoms, weakness, apathy and mental confusion, anorexia and nausea, corresponded with the rather vague clinical picture of mild potassium deficiency. They did not

reach the stage of paralysis. The reason why a potassium deficiency of this degree is so much better tolerated than a comparable sodium deficiency is that sodium can to some extent replace potassium inside the cells, and this is what ultimately happened to Drs. Fourman and Ainley Walker. At the end of his laboratory observations Dr. Fourman went climbing in North Wales, not knowing then how deficient in potassium he still was. He says he "found the mental and physical effort no more than trying", but he was "unaccustomedly breathless going uphill". There is nothing which can replace sodium in the fluid outside the cells.

Calcium

Calcium has chemical properties which make it very liable to form insoluble salts within the body fluids. Eggshells and oyster shells consist of calcium carbonate, and a complex calcium phosphate is the hardening agent in the bones and teeth. This property, which makes calcium so invaluable in one way, makes it a source of difficulty or even danger in another. In the first place it is liable to form insoluble salts in places where it is not wanted. In the second place, it may form insoluble salts in the intestine, and this may prevent enough of the food calcium being absorbed to meet the person's requirement. The fatty acids which are not absorbed in sprue and coeliac disease, for example, precipitate calcium as insoluble soaps and interfere with its absorption. Rhubarb and strawberries both contain oxalates, and these will precipitate some of the calcium in the rest of the diet and prevent its absorption.

Spinach is also rich in oxalate, but since this is already present in the plant as calcium oxalate, neither the calcium nor the oxalate is absorbed. Whole cereals such as oatmeal and wholemeal flour, and to a lesser extent national wheatmeal flour, contain an organic phosphorus compound, phytic acid, which also forms an insoluble calcium salt, and these foods, also hinder the absorption of calcium. It was partly for this reason that it was decided, in 1942, to fortify the national loaf with calcium. Nearly all the calcium in the body is in the bones, but there is a small amount in the extracellular fluids, and, as in the case of potassium, the exact level of this small amount is vitally important. A fall leads to tetany, and without enough calcium the blood would not clot, the heart would not beat, and few of the body cells would function.

The metablism of calcium is regulated by the parathyroid glands and by vitamin D. A deficiency may arise (*a*) if the intake of calcium is too low, or if the diet contains some other substance which precipitates calcium in the intestine and prevents its absorption, or if there is a defective absorption of fat, as in steatorrhoea—the serum calcium may then fall, and tetany and osteomalacia may result; (*b*) if the activity of the parathyroid glands is diminished—this results in a lowering of the concentration of calcium in the serum and the patient often suffers from tetany; (*c*) if there is a deficiency of vitamin D. Without enough of this vitamin human infants and rapidly growing animals get rickets, which is characterized by a failure in the deposition of calcium in the bones. Too little calcium is absorbed from the intestine, but the intervention of the parathyroid glands may maintain the serum calcium within normal limits.

An excess of calcium may arise from hyperparathyroidism. The raised level of serum calcium leads to an excessive excretion of calcium in the urine, and may result in a decalcification of the skeleton and diagnostic changes in its X-ray appearances. Treatment with an excessive amount of vitamin D also causes a rise in the level of calcium in the serum. Because of its liability to form insoluble salts, calcium may be deposited in abnormal sites such as the kidneys and other parts of the urinary system, the biliary and salivary tracts, in the arteries, or under the skin as in calcinosis. It is usually impossible to get rid of unwanted calcium in abnormal sites, but it is often quite easy to make good a deficiency of calcium within the body.

Suckling Anaemia

Milk is well known to be a poor source of iron and most of us were taught that the baby is born with a store of iron in its liver to last it over the suckling period. This idea started in 1899 when Bunge, a German scientist, analysed the livers of some newborn rabbits and guinea pigs for iron, and found that the rabbits' livers contained a high percentage of iron while those of the guinea pigs did not. Young rabbits live exclusively on milk for several weeks, while baby guinea pigs run about and eat other food from the day they are born. Bunge therefore put forward the generalization which has been accepted without question ever since, that the livers of young animals which live on milk during the first part of their lives contain a store of iron to last them throughout the suckling period. It now turns out that the rabbit is quite exceptional in the amount of iron it has in its liver at birth. We know of no other mammal that has nearly so much. The human, the dog, the cat, the pig, the rat all have very much less, and the amount could only go a very small way towards meeting their iron requirements for growth during the suckling period.

Although milk is a poor source of iron, the total quantity of iron in the bodies of most healthy young animals increases during suckling, even of those which are helpless, and this iron must come from the milk, for there is no other source. Human milk is particularly poor in iron—the milk of cats and dogs contains about 10 times as much, but the human baby grows much more slowly than all small mammals so that its daily iron requirements are correspondingly less. The amount of iron the suckling animal can get from its milk, however, is never enough to keep pace with its demands for growth, and the percentage of haemoglobin in the blood falls.

Suckling anaemia is common to all mammals. Nobody knows whether the reduction in the percentage of iron in the body of the suckling puppy and its anaemia handicap it in any way, but suckling anaemia may be a serious trouble in human babies, and there is one animal which may suffer severely under modern agricultural conditions: a newborn pig doubles its birth weight in the first week of its life, trebles it in the second and quadruples it in the third, so that its iron requirements are enormous. Young pigs reared out of doors eat enough soil, which is rich in iron, to provide themselves with plenty of iron to meet their needs. Now that it has become the commercial practice to rear piglets in concrete sties, however, where they cannot get at any soil, piglet anaemia has become a very real problem. Dosing the individual piglets with an iron salt prevents the anaemia but it is a great deal of trouble, and no efficient substitute for a free run on the soil has yet been found.

Nurses and Midwives Whitley Council

A. Training Allowances for Post-Registration Student Nurses

1. The Whitley Council has agreed that the provisions of Part A of NMC Circular No. 11 which were adopted for an experimental period expiring on February 28, 1954, shall, subject to paragraph 2 below, be extended for a further period of three years.

2. The allowances (and the charge for board and lodging where provided) for post-registration student nurses shown in the Appendix to NMC Circular No. 11 shall be payable at the rates set out in Section Ic of the Appendix to NMC Circular No. 30; with the exception that with effect from the date of this Circular in the case of a nurse registered on the general part of the Register of Nurses who undertakes a course of post-registration training of one year's duration only to qualify for registration on the part of the Register containing the names of nurses trained in the nursing of persons suffering from infectious diseases, the allowance payable to her during that year shall be at the rate of £335 per annum.

B. Secondment of Qualified Nurses for Further Training

The Council has also agreed that the provisions of Part B of NMC Circular No. 11, as modified by paragraph 6 of NMC Circular No. 15, relating to the secondment of qualified nurses for further training (other than midwifery training) which were adopted for an experimental period of three years shall be extended for a further period of three years.

NMC Circular No. 36

April 15, 1954.

Recent Advances in the Treatment of Heart Disease*

by J. G. MacARTHUR, M.C., M.B., M.R.C.P.

DURING the last few years notable progress has been made in the treatment of heart disease. In this short review I shall deal in a general way with some of the major advances which have been made in the last decade, and it is natural to begin with those conditions which are present at birth.

Congenital Heart Diseases

Anomalies in the structure of the heart present at birth constitute only about 2 per cent. of all cases of heart disease and this group is therefore numerically not very important. In the past little could be done for many of these unfortunate children and they often led a life of invalidism until heart failure or infection ended their miserable existence. Nowadays the position has changed. The careful studies carried out by Abbott and Taussig in America stimulated increasing interest in accuracy of anatomical diagnosis and the stage was set for surgical correction of some at least of the more common defects. Gross and Blalock in America, Crafoord in Sweden, and Brock in this country, by brilliant surgical techniques have made possible complete cure in some of these cases, such as patent ductus arteriosus, and considerable improvement in others such as Fallot's tetralogy. Nor must it be forgotten that the special techniques of cardiac catheterization and angio-cardiography have greatly increased the possibilities of accurate pre-operative diagnosis and the selection of those patients who are suitable for operation. Modern anaesthetic techniques and the wide range of antibiotics now available have also contributed to successful operation. There is hope that increasing numbers of these defects will become amenable to surgical correction. Unfortunately we are still largely ignorant of the basic causes of congenital heart disease and this represents a challenge to future medical research.

Rheumatic Fever

Although rheumatic fever does not always involve the heart, it is the most important cause of heart disease in young people. Little progress has been made in its treatment, and I include it only to mention that the introduction of cortisone and ACTH gave promise of new remedies to combat it. Unfortunately these hormones, though capable of controlling the fever and joint pains, appear to have little effect upon the cardiac lesions and relapse occurs when they are withdrawn. It would seem that the answer to this problem must surely lie in the prevention of streptococcal infection with which rheumatic fever is so closely linked.

Rheumatic Heart Disease

Rheumatic heart disease accounts for about 25 per cent. of all cases and its maximum incidence is in children and young adults, though some of its victims reach middle life and old age. The rheumatic process produces scarring of the heart valves, leading most commonly to narrowing of the mitral valve (mitral stenosis) or, less often, disease of the aortic valve. The tricuspid valve is much less frequently affected and the pulmonary valve almost never. In addition damage is done in varying degree to the heart muscle. The usual outcome is heart failure in early middle life and a minority of sufferers reach the age of 40. Digitalis, diuretic drugs and a salt-free diet are the mainstays of treatment of heart failure and much can be done to improve these patients with such therapy.

In recent years a great advance has been made by the surgical treatment of patients with mitral stenosis. It is now possible in many cases to enlarge surgically the orifice of the narrowed mitral valve so that a more nearly normal anatomy is restored. Many hundreds of sufferers have now had this operation performed, and the immediate results are most gratifying. Patients who have been greatly incapacitated by breathlessness on exertion have been restored to reasonable health and returned to work. Indeed some patients have been able to undertake gainful employment for the first time in their lives.

The operation of mitral valvulotomy or valvotomy is undoubtedly one of the greatest advances in treatment of heart disease of the past decade. Not everyone suffering from rheumatic disease is suitable for operation and reasonable improvement is likely to occur only in those patients whose symptoms are due to narrowing of the mitral orifice. Severe degrees of aortic valve disease are not yet amenable to treatment though minor degrees do not constitute a contra-indication to operation when the main lesion is mitral stenosis.

Subacute Bacterial Endocarditis

Subacute bacterial endocarditis is a serious illness which is most commonly a complication of rheumatic heart disease, though fortunately it is a relatively rare disease. Organisms, usually streptococci, grow upon the damaged heart valves and produce a form of blood poisoning which in the old days was almost always fatal. Nor did the introduction of the sulphonamides in the late 1930's materially alter this gloomy prognosis. The advent of penicillin, however, radically changed this state of affairs and it is now possible to cure this infection in most patients by the use of this drug in adequate dosage and for a long enough time (2,000,000 units daily for six weeks). A small proportion of cases require the combined use of penicillin and streptomycin.

It is important to note that the source of infection in these cases is very often the patients' mouths and the disease often develops after dental treatment (for example, tooth extraction). After dental interference, organisms of this type can often be grown from the bloodstream and in persons with healthy hearts no apparent harm results. In patients with rheumatic (and some other forms of) heart disease, subacute bacterial endocarditis may develop and it is therefore important that such patients should have regular dental inspection, and an adequate dose of penicillin should be administered to the patient a short time before any dental operations are carried out.

Hypertensive Heart Disease

High blood pressure accounts for about 30 per cent. of all cases of heart disease and mainly affects patients in later life. Although in some cases the cause of the hypertension can be determined, the basic mechanisms which produce the rise in arterial blood pressure are still very imperfectly understood and prevention of this condition and its effects upon the various organs of the body is one of the unsolved problems of modern medicine.

Treatment is therefore directed towards lowering the raised blood pressure and maintaining the blood pressure at a more normal level.

Numerous drugs are known which can lower a raised blood pressure but very few are of any practical value in the treatment of hypertension. In recent years most attention has been paid to the methonium compounds commonly known as C_5 and C_6 and in some cases considerable success has followed their use. They have, however, usually to be given by injection and tolerance to their action quickly

* *Abstract of a lecture given at a study day of the Glasgow Occupational Health Group of the Royal College of Nursing.*

develops. It is therefore difficult to maintain adequate control of the blood pressure and although these drugs are a considerable improvement on the older preparations the ideal drug for use in hypertension has yet to be found. Diets low in sodium and drugs which prevent the absorption from the gut of sodium have also been used in recent years, but such treatment is difficult to maintain indefinitely. Alternative methods of treatment include surgical section of the ganglia of the sympathetic nervous system and partial removal of the adrenal glands. These operations are usually reserved for the rapidly advancing severe forms of the disease and they have led to striking improvement, at least temporarily, in a number of instances of this type of case.

Ischaemic Heart Disease—Coronary Artery Disease

The increase in the incidence of disease of the coronary arteries in recent years has been striking and is apparently not wholly accounted for by increased accuracy of diagnosis and the increasing age of the population. It is characterized clinically by angina pectoris and cardiac infarction and the hallmark is pain across the chest. In the former the pain lasts for minutes—in the latter usually for hours.

Treatment of angina pectoris has advanced but little in recent years and the use of nitroglycerine remains the most important means of controlling and avoiding the attacks of pain. Newer drugs such as khellin and pentaerythrytol-tetranitrate may help to prevent attacks but are valueless in treating the individual attack. The correction as far as possible of contributing factors such as obesity and diabetes remains important.

Surgical methods designed to abolish the pain by section of the sensory nerves of the heart or to increase the blood supply to the heart have occasionally succeeded.

Cardiac Infarction

This is usually due to clotting of the blood in a diseased coronary artery with consequent death of a part of the heart muscle supplied by that vessel. A major advance in recent years has been the introduction of drugs which prolong the clotting time of blood and so tend to prevent the occurrence of further thrombosis. Death following coronary thrombosis is not uncommonly due to further thrombosis or embolism and the mortality rate can be considerably lowered by the use of the anticoagulant drugs. Drugs such as heparin ethylbiscoumacetate and phenylindanedione are now used as a routine in severe cases of cardiac infarction, especially in the older age group, though in younger patients and in less severe forms of the disease their use may not be so imperative.

I have tried to place before you a few of the more important advances in the treatment of heart disease and I hope that I have convinced you that much can now be done to help those with serious cardiac disabilities.

Case Study Competition, 2nd Prize

Round and Whip Worm Infestation in a Child

by SHEILA M. RAWS, Student Nurse, Royal Manchester Children's Hospital.

ON August 11, 1953, a two-year-old child was admitted to the Royal Manchester Children's Hospital, Pendlebury. For the last six months she had been passing a round worm two or three times a week. She had also been vomiting them, and a specimen was produced from the previous day. She had had diarrhoea, and blood had been seen in stools and vomit. She had been unwell for six months, gradually losing weight and becoming very peevish and irritable. She had lost 1 lb. in a month before admission. During this time her appetite had been variable.

The child was a normal baby, delivered at term. She was breast fed until six months old. At the time of admission she would take normal diet. She was never fed by bottle, but was weaned from breast milk to solid diet.

She sat up when six months old and started to walk between the ages of 14 and 16 months; she had been able to stand at one year. Her first milk teeth did not appear until she was 11 months old (the normal time being from six to eight months in most babies). She passed urine satisfactorily but was quite often incontinent of urine and faeces. She spoke only a few words on admission.

Family History

There are four children in the family, two being younger than the patient. She used to live in Ireland. Her father and other members of the family have had tuberculosis, the father being at home. The mother weighs only 6 st. at present, having weighed 10 st. previously. The mother was apparently disinterested in the child and so, with the parents' consent, she was brought from Ireland to live with her aunt. The aunt is a well-meaning woman, with two children of her own. She intends to keep the child for good and appears fond of her.

The almoner reported that the home had four rooms but only two were in use. The house was not very clean, the kitchen was dark and had only one tap for cold water. The standard of hygiene was extremely low. The family all slept in one room, the patient sleeping with the two girls.

The uncle was unsuccessfully treated for tape worm three years ago, but the other two girls are apparently healthy.

On examination, the child's temperature was normal, her pulse and respirations slightly rapid. She appeared very ill and was too weak to stand or run about. She appeared a thin, wasted infant, and was found to weigh only 16 lb. The abdomen was rather prominent but nothing abnormal was found on palpation. She was very small for her age. Her nails showed slight clubbing and she was cyanosed. Her tonsils were large but clean.

Nursing Care

The child was bathed on admission and was found to be very dirty. Her hair was infested and was, therefore, treated with D.D.T. hair emulsion. She was barrier nursed, especially strict precautions being observed with regard to her toilet when she was being changed and bathed. She was given a daily bath, the bathing blanket being disinfected and sent to the laundry immediately after use. Her hair was inspected with a fine tooth-comb each day and was treated with D.D.T. hair emulsion and washed whenever necessary.

Her temperature was recorded four-hourly for the first four days. It was not elevated and was therefore recorded twice a day after this. Her fluid intake was strictly recorded. It was not possible to record the amount of urine passed as she was frequently incontinent. All her stools were recorded and described. They were usually large, loose, offensive stools, sometimes containing undigested food.

After a few days she seemed stronger, and she was allowed to be in a play-pen during the afternoons. She was fond of dolls, highly intelligent and took great interest in what she was doing and in what was happening around her. She was very affectionate by nature and extremely mischievous.

She was frequently incontinent of urine and faeces, but

through steady training, greatly improved.

Extra fluids, including plenty of milk drinks, were given at least four-hourly, as well as at meal times.

Her skin was very sensitive and easily became chapped during cold weather. This was treated by not using soap, by drying the skin gently but thoroughly and applying half-strength Lassar's paste. Two ounces of fresh orange juice daily gave her extra vitamin C.

On the day of admission, the child had an X-ray of her wrist which appeared 'knobbly' but there was no lesion detected. She also had a chest X-ray which showed a slight nodular consolidation of the lower lobe of the right lung.

A specimen of stool was sent to the laboratory for microscopical examination.

Medical Treatments

August 17. Treatment for nematoda was commenced. A saline purge of magnesium sulphate, 2 drachms, was given at 8 a.m., followed by hexylresorcinol 0.6 g. at 9 a.m. and another 2 drachms of magnesium sulphate at 10.30 a.m. A specimen of stool was then sent to the laboratory and the pathologist reported that an occasional whip worm was seen.

August 21. The chest X-ray was repeated. This one suggested bronchitis but no consolidation was visible this time. She was given a Mantoux test for tuberculosis, by means of an intradermal injection of tuberculin 1 : 1,000. This proved negative, and was therefore followed by two more injections of 1 : 100 and 1 : 10 which, however, were also negative.

Her stools were now very loose but less frequent. She was gaining weight (1 st. 2 lb. 5 oz.) and she had a good appetite.

August 27. A course of ferri et ammon. cit., gr. 5, three times a day, was commenced as she was rather anaemic. This was continued until January 2, 1954. Several long round worms were passed during the following days and four or five soft stools were passed per day.

September 3. A high glucose and milk diet was given for two hours and was followed by carbon tetrachloride, 5 minims, but no purgative or starvation was necessary before the administration of the drug.

September 8. A dead round worm was passed. Stools were microscopically examined once more and were found to contain ova of round worms and whip worms. Meanwhile her haemoglobin had risen from 58 per cent. on admission to 64 per cent.

September 15. Glucose fluids only were given, to be followed the next day by further treatment for round worms. The child was not given any breakfast, and oil of chenopodium, 2 minims, was given at 8 a.m. and 9 a.m. Magnesium sulphate, 2 drachms, was administered at 11 a.m.

This course was repeated two days later. On the third day, 10 live round worms were passed. The faeces contained scanty unfertilized round worm ova and scanty whip worm ova.

September 22. Another dead worm was passed. Oil of chenopodium seemed to have been the most effective treatment and it was, therefore, repeated after 11 days. Six round worms were passed the day after this second course, 46 having been passed between August 11 and October 7.

Improvement in Weight

The chest X-ray still showed no appreciable change. The child was continuing to gain weight (1 st. 5 lb.) and she seemed happy and full of mischief as always. A liver function test showed thymol turbidity only.

October 12. A course of Antepar was started, half a teaspoon three times per day being given for seven days with saline purges, 2 drachms, on alternate days. Ova could still be seen in the faeces after this course. She was given a barium meal to show up any worms, but this was not very successful.

November 11. Velardon was given. This was a drug especially imported from Denmark which was guaranteed to kill all types of worms. One drachm of castor oil was given the day before the treatment. The contents of the packet were taken with a little water during the course of the day, on an empty stomach. Light diet, as little as possible, was given during the day of treatment. No laxative was given afterwards. As a result of the Velardon course, numerous offensive stools were passed. A specimen of stool was examined by the pathologist for disintegrated worms. The result showed whip worm ova and protozoon infection. There was no longer any round worm infestation. The patient was very pale and 'grey looking' after treatment, but otherwise she was as lively as usual.

November 19. More treatment was given for worms, mepacrine, 50 mg., being given twice daily for three days. This cleared the protozoon infection but whip worm still remained. She was therefore given a course of aureomycin, 250 mg., twice daily. This, however, had no effect either.

December 29. Benadryl, 50 mg., was given daily for 10 days in a further attempt to kill whip worms. A specimen of stool was sent to the laboratory, after this treatment, but whip worm ova were still present.

January 30. The child did not appear to be gaining weight satisfactorily. Also her stools were very loose and many contained undigested food stuffs. Therefore it was thought that a gluten-free diet would be beneficial. This was fairly successful and she gained weight. Her stools were still soft and relaxed although she did pass a few formed ones occasionally.

January 22. Another remedy was tried for whip worms. Tetrachlorethylene, 0.4 cc., was given in capsule form, 2 drachms of magnesium sulphate having been given the previous day. Two hours afterwards another saline purge, magnesium sulphate, 2 drachms, was repeated but no food was given until she had passed a stool. The same course was repeated a week later as the pathologist reported fewer whip worms. She showed no toxic effect from any of her drugs, as might have been expected.

January 28. The child complained of earache. It was thought that there might be some foreign body present, but on inspection it was found that her outer ear was infected and there was slight otitis externa. A sodium sulphate wick was inserted for one day only and her ear rapidly improved.

February 1. Her weight was now 24 lb. and she was gradually progressing. Another course of Benadryl emplets was given.

The child still remains in hospital as whip worm ova are still to be found in her stools on microscopic examination. It is, however, hoped that a cure will soon be effected so that she may return home.

BOOK REVIEWS

The Nurse's Dictionary

—originally compiled by Honnor Morten. Revised by Florence Taylor, S.R.N., I.S.T.M., S.C.M., Diploma in Nursing, University of London, and Jean Cunningham, B.A., S.R.N., S.C.M., H.V.Cert. (Faber and Faber, Limited, 24, Russell Square, W.C.1, 6s.)

This is the 23rd edition and although still called a pocket-book it is getting larger. In some ways this makes the book more valuable as the diagrams are clearer and the text easier to read. Much new material, such as the names of modern drugs and diagrams of the standard blood transfusion apparatus, has been added, in fact there must be very little information that the student nurse will not be able to find here.

There are various appendices: Urine Testing which is the first, now gives details about the Fantus' quantitative test; Appendix IV on Diets has some new additions and is now followed by a series of recipes for sick people; the appendix on First Aid is little altered but following it, at the end of the book, is some very useful illustrated information on instruments in common use, with notes on sterilization and an adaptation from the Medical Research Council pamphlet on

Prevention of Hospital Infection of Wounds dealing with the technique of ward dressings.

If a nurse does not already possess a dictionary this is one she should buy.

B. T., S.R.N., S.C.M., Sister Tutor Cert.

Anatomy and Physiology Laboratory Manual

(illustrated).—*by Arthur W. Glass, M.A., and Charles Hamrum, M.A. (W. B. Saunders and Co. Limited, 7, Grape Street, London, W.C.2, 7s. 6d.)*

This is an American production which gives a series of exercises and experiments as used in the laboratory for human anatomy and physiology at Gustavus Adolphus College, Minnesota.

A description of the microscope is followed by some very clear diagrams of cells and tissues. The section on the study of the blood, although interesting to the nurse, is not part of her curriculum; and the diagrams of the skeleton, useful in that the student herself has to label the anatomical details, can be found in her more detailed standard textbooks. In the same way, the diagrams for the various muscles to be drawn in by means of coloured chalks could be found in other anatomy textbooks.

Apart from the early diagrams this book could not really be recommended for the student nurse, but it might prove useful for a post-certificate student.

B. T., S.R.N., S.C.M., Sister Tutor Cert.

Pitman Medical Dictation

(with Dictionary of Pitman Outlines). (*Sir Isaac Pitman and Sons Ltd., Pitman House, Parker Street, Kingsway, London, W.C.2, 15s.*)

This book has been designed to prepare shorthand writers for medical secretaryship, but would be equally useful for the medical or nursing student attending lectures. It is divided into two parts, the first dealing with medical correspondence and general medical and surgical dictation, and the second consisting of an extensive shorthand vocabulary of medical terms.

The first section of Part I covers medical correspondence with only a few medical terms (each exercise actually originating in a doctor's office or a hospital), the second section is of more advanced medical dictation and gives the student as broad a training as is possible within the limits of one book. The third section contains excerpts from reports taken from medical records referring to the various systems as well as to surgery on the special sense organs and regions of the body.

The vocabulary of medical terms listed in Part II, under prefixes, suffixes, medical compound words, standard medical abbreviations and symbols, gives a good deal of valuable information to students and medical secretaries which should help them considerably in their work.

D. A. P.

Bless This Roof

—*by Julia Burton and Phyllis Garlick. (The Highway Press, 6, Salisbury Square, London, E.C.4, 3s. 6d.)*

The ' roof ' of the title is that sheltering a home and the emphasis throughout is on the developing of Christian homes among the Yoruba tribe of Western Nigeria. The book shows the many difficulties facing Christians in the midst of a pagan community. The problems are described simply and clearly and are not minimized. No condemnation but much concern is expressed at the numbers of nominal Christians and the harm that their lives and examples do to the cause of Christianity, which might well be taken to heart by many in this country and certainly by those who go to overseas countries. The story is told in terms of a Christian girl from a pagan home who trained in a mission hospital as a nurse and midwife and worked as a midwife in a remote village.

The later part of the story stresses the urgent need for the education and training of women in any community before there can be real advances in standards of life. Their influence on the home cannot be over-emphasized. This book is written from the missionary standpoint and no mention is made of the Government service contribution to the same problem, but undoubtedly Christians working in that service have an equal responsibility to carry.

G. M. H., S.R.N., S.C.M., H.V.Cert.

Books Received

Textbook of Practical Nursing (fourth edition).—*by Kathryn Osmond Brownell, R.N., B.S. (W. B. Saunders and Co., 22s.)*

Common Sense in the Nursery.—*A Cedar Book No. 11, by Mrs. Sydney Frankenburg, M.A., S.C.M., J.P. (The World's Work (1913) Ltd., 2s. 6d. paper, 9s. 6d. cloth.)*

For Student Nurses

PRELIMINARY STATE EXAMINATION
Elementary Anatomy and Physiology

Question 1. *How is the temperature of the body maintained within normal limits ?*

The normal temperature of the body is approximately 98°F. In temperate climates this is higher than that of the surrounding air. In health it remains comparatively constant, seldom varying more than one degree in either direction. The temperature is determined by the heat inside the body and is kept within normal limits by maintaining a balance between heat loss and heat production.

Heat Production. Heat is produced by muscle activity and by the metabolism of all cells, some of which—for example, the liver cells—liberate large quantities of heat. Metabolism, in turn, is controlled by the secretion of the thyroid gland, and is accelerated by the release of adrenalin.

Heat Loss. Heat is lost from the body in the following ways.

1. By the evaporation of sensible and insensible perspiration.
2. By radiation to the cooler surrounding air.
3. By convection currents.
4. By direct loss through conduction to adjacent objects.
5. In expiration.
6. Small quantities of heat are lost in the urine and faeces.

A Suggested Answer to a State Examination Question, by the Sister Tutor Section, Royal College of Nursing.

The heat centre is thought to lie in the hypothalamus. This centre is sensitive to the temperature of the blood in vessels which run near it, and responds by means of the sympathetic nervous system. This section of the nervous system controls the degree to which the peripheral vessels are constricted. Thus when fewer impulses reach the vessels they tend to dilate, so more blood is brought nearer to the surface of the body and heat loss is therefore increased. Similarly the sweat glands which are present in the skin are also under the control of the sympathetic nervous system, and when they are stimulated, heat is lost from the body in the evaporation of their secretion. Sensory nerve endings found in the skin are stimulated by variations in the temperature of the blood in the peripheral vessels and when this is increased sweating is provoked. This is seen in the sweating which follows muscular exercise.

Conversely, when the temperature of the body tends to fall, the peripheral vessels become more constricted and so the body tends to retain its heat and the activity of the sweat glands is inhibited. Skeletal activity is increased and may show itself by a sudden attack of shivering.

To aid the body in keeping the temperature within normal limits, variations may be made in the temperature of the food to be ingested, hot or cold applications may be made to the external surfaces of the body, and the number and type of coverings may be adjusted.

A busy scene in the dispensary at Butere, a rural health centre serving 87,000 people of the Luo and Abuluhya tribes.

Preventive Medicine in Kenya

AT BUTERE HEALTH CENTRE

STEADILY Kenya is building up its chain of health centres throughout the Colony in accordance with the Medical Department's aim of not only taking curative medicine into the home, but conducting organized team attacks to prevent disease.

By its very nature, progress in this field cannot be spectacular and the chain of 400 locational health centres envisaged for the whole Colony will take many years to materialize. Yet from the limited financial resources available, much has been achieved and certain areas are more fortunate than others in the number of health centres already in operation. North Nyanza, for instance, thanks to its wealth from good successive maize and cotton crops, has had the money to finance, through its progressive African District Council, as many as nine health centres, plus one mobile health unit to serve the more remote places. But even so, only the surface is being touched—hospital accommodation works out at about one bed per 1,000 and the nine health centres serve a district with 850,000 people.

The master plan for Kenya's medical services involves a few district health centres or hospitals with a handful of Europeans in charge, backed up by a network of these locational health centres entirely run and staffed by Africans. These centres are in nearly all cases paid for and maintained by the African District Council concerned. Butere is an outstanding example of a health centre in a rural area and much of its success has been due to the medical - assistant - in - charge, Joash Adhalo, who was trained at the Medical Training School in Nairobi. The Centre serves 87,000 people.

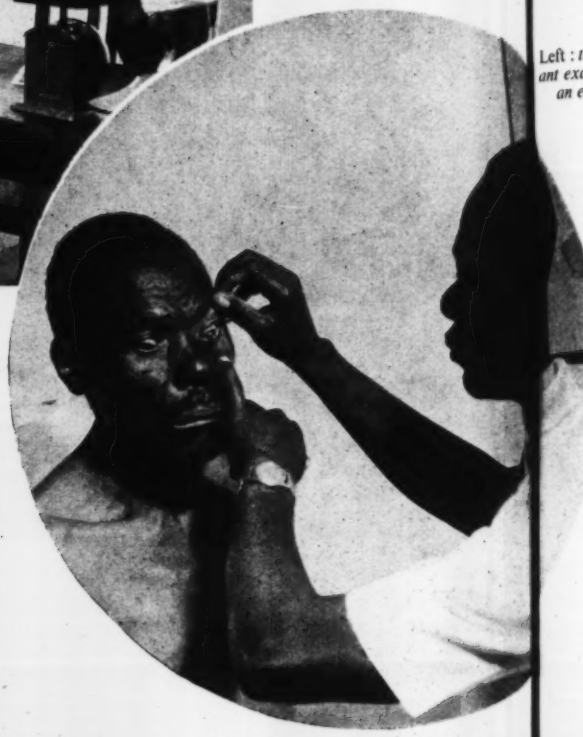
Three thousand patients a month

(*continued on page 478*)

The nurse gives a health talk to mothers, using one of the babies for demonstration purposes.

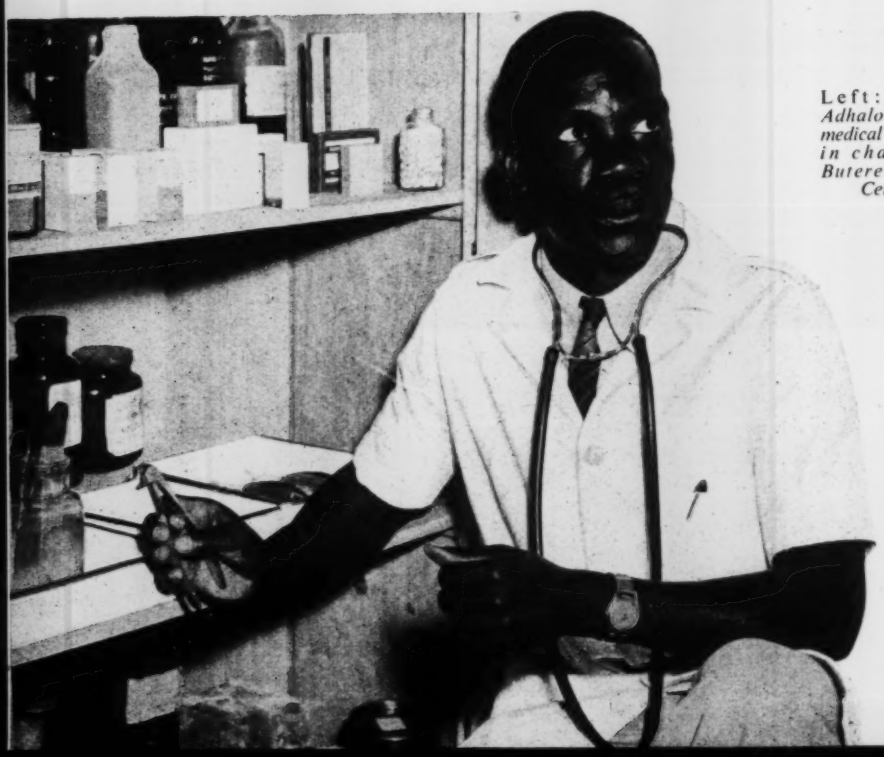
Left : *the nurse talks to mothe natal clinic; antenatal and p are held regularly.*

Right: *a view of the buildings Butere—this c* 6,000.



Left : ant ex an e

TEAMWORK ATTACK ON DISEASE



Left: *Joash Adhalo is the medical assistant in charge of Butere Health Centre.*

Left : *the medical assistant examines the eye of an elderly patient.*

Left : *the midwife takes notes from expectant mothers at the antenatal clinic. These clinics are ideal for imparting health propaganda.*

A HEALTH CENTRE STAFFED BY AFRICANS

Left : *one of the two African dressers attending a patient.*

Right : *one of the many jobs falling to the health inspector is seeing that water supplies are kept clean and unpolluted. Here he is (left) helping to construct a protected spring.*

The medical assistant from the centre, followed by the health inspector, has arrived by motorcycle to attend a patient in the district.

bringing health to the villages

(*continued from page 475*)

pass through the hands of Joash Adhalo and his helpers—the midwife, the health inspector, the woman health visitor, the nurse and the dresser. Not all the 3,000 by any means come to the health centre building outside Butere, for the staff's job is to go out as a team to prevent disease getting a hold and, by educating entire families in proper methods of hygiene and preventive measures, to reduce the incidence of disease and keep the demands upon actual hospital accommodation to the minimum.

A remarkable example of this domiciliary work was recently provided when typhoid broke out among the huts in the fields of tall, waving maize about six miles from Butere. As soon as the outbreak was notified, the Butere team got to work. TAB injections were given to a large number of people in the vicinity and the victims were carefully treated. As a result, what might have been a serious epidemic was checked. Only five victims had died before the outbreak was under control.

But while visiting the homes and shambas of the area constitutes an important part of the work of the health centre, there is a series of clinics to be run regularly in the centre, ranging from general diagnosis and treatment, to the leper, V.D. and tuberculosis follow-up clinics. There are also the midwife's antenatal and postnatal clinics. Object lessons in the clinics are proving one of the most effective ways of providing health information. In the antenatal clinic, for instance, sick, ailing babies are shown to the assembled mothers and their progress watched from week to week on proper food. The health visitor carries on the same propaganda in the home and the school, while the health inspector gets to the very root of the disease problem; at Butere, he is busy with a campaign for general cleanliness and sanitation, involving properly protected water supplies, refuse disposal and a host of other details all directed towards making the people hygiene-conscious. Every effort is being made at the Nairobi Medical Training School attached to the King George VI Hospital to keep pace with the demand for staff for the new health centres and within a few months trainees will be housed in a new building.

Prophylaxis against typhoid. The medical assistant tells the mother how very much more effective inoculations are against typhoid as she shows him the herbs she has been using for her son.

inoculation or herbs— now they have the choice

Aspects of Mental Health in the Public Health Field*

by T. J. HENNELLY, M.D., B.Ch., D.P.M.,
Physician Superintendent, Whitchurch Hospital, Cardiff; Lecturer in Psychological Medicine, Welsh National School of Medicine; Consultant Psychiatrist, United Cardiff Hospitals.

THIS is the age of the machine in medicine and the growth of specialties has tended to shut out the patient as a person, leaving him more sick and more confused than ever before. Coming as it does in an age of widespread paganism and irreligion it has left the patient adrift, unable to seek help or solace from a God he ignores or knows not of, and getting little or no comfort from a physician who sees him only as a symptomatic heart or kidney or some other separate part, and who labels him in his mind not as a personality but as that case with this symptom. By respecting the God-made personality of whoever it is confronting you and being prepared to listen (you will learn the technique only by experience) you will *not* be making yourself, nor does anyone *want* to make you, into a psychiatrist or a psychiatric social worker, you will be making yourself a far better and more skilled practitioner of your own particular subject than you could ever hope to be without consciously realizing and practising these now widely-accepted truths.

The Key to the Future

Now we arrive at the key to all future mental health—the child. It has been well said that " the full human and social benefits of mental health will only come with the generation following the one that achieves a fair degree of mental health. That is the reason why the education of the general public in the elements of applied psychology is truly a matter that calls for urgent action." The greatest problem of illness in the community today is undoubtedly that of mental or psychological or psychosomatic or emotional or stress or nervous illness, call it what you will. Illness of the person, perhaps, as opposed to illness of the body or of one of the organs. We may not always be aware of the tremendous energy contained in our emotional feelings until something occurs to tip us off balance, causing a spill-over into a state of dis-ease—all illness is a state of not being at ease—and we find ourselves ill or with symptoms. If the state of disease is caused by the pneumococcus or by inflammation of the appendix or by the meningococcus or B. typhosus we calmly deal with the situation and apply the appropriate remedy.

Suppose, however, that we find the person or child looking frightened, heart palpitating, respiration increased, gasping for breath, arms and legs trembling, complaining of severe headache, perhaps with vomiting and diarrhoea and we find no coccus or inflammation but a perfectly sound body, do we then as calmly seek for the noxious agent and apply the appropriate remedy ? In far too many cases I fear not. Simply because we do not understand. The patient has all these symptoms in all these different organs, head, heart, lungs, muscles, stomach and gut; he can feel them all and is ill; you can observe them all, they are factual; and yet there is no disease in the popular sense. The explanation, of course, is that the organs of the physical body act as sounding boards for the emotions or feelings and when any one of these (be it fear, anxiety, love, frustration, rage, hate, embarrassment or shame, each of which is as normal a part of us as our blood or our bones or our bile or pituitary secretion) is upset, or disturbed, or provoked, the energy it contains spills over into the involuntary or autonomic nervous system controlling the internal organ or organs which have absolutely no power to resist reacting precisely according to their purpose and function in the body: and so we get the symptoms. I blush, that is, dilate the blood vessels of my cheeks, because I am embarrassed, I palpitate because I am over-anxious or frightened, she vomits because she rejects her pregnancy, or all these things may happen without any conscious knowledge at all. Why is there blushing or palpitating or vomiting ?

We know that only a small part of the mind, analagous to the top tenth of the iceberg sticking out of the sea, is conscious. We accept nowadays that a huge part of our mind and mental working, corresponding to the rest of the iceberg, is below conscious level and therefore subconscious. What is extremely difficult for us to see and accept is that the coral sea of life's accretions, of submerged unconscious experience, is in continuous volcanic dynamic action and potentially liable to upheaval at any time for reasons that may be quite unknown to the calm and placid sea of consciousness. There may be mysterious explosions accompanied by eddies of symptoms for which the surprised and ill-at-ease patient goes to his doctor and asks for relief. How can these mysterious explosions with their associated neurotic symptoms occur; in other words, how do these psychoneurotic illnesses arise ?

It is generally agreed today that the causes mainly lie and are to be sought in the defective personality development of the child and that the structure upon which future mental health is to be built is the life experiences of that developing child from the moment of his birth. Here, in this time of development, and even before it with the pregnant mother, is where public health can enter the greatest of all preventive fields, for it already has the access and the means and only requires the requisite knowledge, skill and will. Health workers must get used to dealing with the subject of future preventive work from the moment of conception onwards, for that is the moment when new life occurs.

The Structure of Personality

From the time when independent existence begins every possible thought, feeling, action, happening, occurrence, every relationship with every other person, every slight, act of love, jealousy or rage, every experience remembered or forgotten, shares its responsibility with every other thought, act, experience or feeling of whatever kind to form the personality of the individual. Once this self-evident fact is grasped, the future of the individual can, apart from external accidents, be approximately assessed and determined.

In other words if we see the personality of a person as we might see a house that is made of bricks, the sum total of the structure contains thousands of individual bricks. In the individual every single experience is a brick built into the structure of the personality, where it may be external and be seen or felt, or internal and hidden and out of sight. If the bricks are all soundly laid from the beginning the structure is and will continue to be all right. If the bricks are faulty at any stage, or improperly or ignorantly laid, then by so much will that structure be, and continue to be, faulty unless the fault when it occurs is detected and corrected. If it is not detected the structure may appear sound, but should any stress or strain or storm be imposed on it later on in life then the faults and weaknesses will become apparent and the structure may be unable to take the strain; it may crumble or be distorted, or there may be a compromise solution which in the patient will show itself in the symptoms of illness, psychoneurotic,

**Conclusion of an address given at the quarterly meeting in Cardiff of the Public Health Section of the Royal College of Nursing.*

psychotic or psychosomatic. It may then become necessary for the psychiatrist to go right back to the faulty and badly laid bricks of experience, expose them (by analysis) and rebuild them or their substitutes more firmly into the structure of the personality. We all need other human beings to depend on, to love, to dominate at times or to be angry with, in short to practise adaptation with so that we can develop, grow and mature. It follows that defects in the brickwork will be found to be due to faults in relations with other people in the environment at some period of growth. Hence it is that health visitors and nurses working in the homes may be compared with bricklayers, helping to lay for the future good sound healthy human personalities.

Of First Importance

What is important then is the home or environment or family in which the child has to live and grow and this environment is affected by his relationships with the people in it. If these relationships are generally harmonious and there is no sustained friction the child feels loved and secure and develops normally. If, however, he has no one person to depend on day by day, for example, if his mother dies or he is orphaned and in a home, or if there is friction between his parents, quarrels with their tension and anxiety, then the child may show various distortions of personality, retardation of both intellectual and emotional development, will tend to grow up in isolation, unable because of his insecurity to be outgoing and friendly towards others (that is, unable to make harmonious personal relationships with others) and may end up with a neurosis or a psychosis or be a delinquent or antisocial criminal revenging himself on his home and on society, towards both of which he has grown up hostile, aloof and embittered. He will, of course, have no knowledge of the mechanisms that cause or determine his distorted or criminal behaviour.

The public health nurse can influence mental health tremendously in this sphere, taking an active interest in the well-being of every baby and young child in the families in the area for which she is responsible. She can protect the children by reducing tensions and stresses in the homes and educating the parents in the worth-whileness, even for their own happiness, of learning how to live harmoniously. A child is always affected or infected by his environment; bad emotions like friction, insecurity, hate, hostility, rejection are disease carriers as dangerous and perhaps as lethal as typhoid carriers used to be, and the emotional diseases are further transmitted down the line from generation to generation—for as the twig is bent so is the tree inclined. The character, temperament and qualities of children are no more than reflections of similar characteristics in their parents and families. The heredity is environmental, not genetic. There is an old Latin tag *nemo dat quod non habet*—no one can give what he has not got—and this is the quintessence of what happens with deprived children. They cannot give, for they do not possess, the love and affection they did not get and they are as a result social failures in their relationships with other people and the community; in their turn when they marry and beget children they spread the contagion in ever-widening circles.

We should also remember when dealing with children or indeed with any touchy adult, that it is the *felt* deprivation rather than any actual or real deprivation that is important. Delinquent children seldom come from happy, united families; they are the products of neglected, careless, unhappy, quarrelling and broken homes. The unpleasant people we meet in life are those who were deprived or starved of love and affection when young and who go through life seeking it without knowing it and never being able, fearing rebuff, to make satisfactory human contacts or relationships.

Where any such conditions are found in families, where tensions are obvious, where there are behaviour difficulties with the children, the health visitor can do invaluable work in getting these tensions and troubles poured out on to herself; the confession of the troubles often extracts their poison and without any special training, but with sympathy and understanding and willingness to listen, advice can be given on how to smooth out the tensions and the troubles in a rational and adult and realistic manner rather than in the commonly immature, childish, dependent, emotional aggressive manner which is the only way these basically poor, and poorly nurtured personalities, have ever known how to react.

A warning is necessary here—all this will take time, an immense amount of it. If you are going to enter the mental health sphere you set yourself out to understand people and how they work. You can only do this by letting them tell you. There is simply no short cut to this even for the most expert psychiatrist. The only way to get a proper history is to let the patient tell his story in his own way. You must have infinite patience and no matter what the hurry may be, you must conceal from the patient that there is any hurry. You are wholly his. The questionnaire or form-filling or keep-to-the-point type of history is utterly useless when dealing with a person and his emotions.

Avoiding Conflict

In families, again, there is a most important role to play in preventing the spread of anxiety by being able to give reassuring and common sense advice on the rearing of children. We know that any anxiety in the mother is transmitted in her breast milk to her infant, resulting in digestive upsets. Treat the mother, not the child. Similarly, mothers must be taught to 'lay-off' their children, that is, avoid conflict in toilet training, cleanliness, bladder control, thumb-sucking and so on. The keynote is relaxation, humility, and the knowledge that nature was in this emotional game long before you or the mother concerned arrived on the scene and can safely be left to deal with these matters, as she will, at the appropriate stage in time as the child progresses.

Sibling rivalry on the advent of the new baby is very real and it is a part of the mental health educational process to remind the expectant mother to prepare her child so that he will co-operate in minding *their* new baby instead of, as so often happens, regressing and soiling and sometimes getting really ill with despair at feeling itself supplanted by the newcomer.

Once the school stage is reached the maturity, considerateness, understanding and personality of the teacher is most important, for the teacher wields a powerful influence on the developing child second only to that of the home itself.

If childhood has progressed smoothly so will the other

Left: *in deep discussion at the Public Health Section Meeting in Cardiff in January; left to right: Miss M. E. Morgan, hon. secretary, Public Health Section within the Cardiff Branch; Dr. Powell Phillips, deputy medical officer of health, Cardiff; Alderman W. A. Hancock, chairman, Glamorgan County Council; Miss E. M. Wearn, chairman, Public Health Section Central Sectional Committee; Dr. W. E. Thomas, medical officer of health, Glamorgan County; Miss I. H. Charley, hon. treasurer, Public Health Section.*

[by courtesy Western Mail and Echo Ltd., Cardiff]

Needs and Resources

A reprint of this series of five articles by Mrs. N. Mackenzie, M.A.(Oxon.), can be obtained from the Manager, *Nursing Times*, Macmillan and Company Limited, St. Martin's Street, London, W.C.2 (1s. 6d. plus postage 2d.)

in the Nursing Profession

epochs in life, for each stage from childhood to the grave brings to the next all the accumulated strengths and weaknesses of the preceding stage, all the fears, the doubts and the inferiorities but also, we may hope, the necessary courage, assurance and resilience to overcome them healthily.

There are quite literally illimitable fields of preventive mental health work open to public health once it is understood that there is more health to be saved in fostering good human relationships amongst people than is possible in any other of the fields of medicine today. The world is full of lonely, dependent people perhaps because industrialization has uprooted the close-knit peasant communities and scattered small isolated units or families in rows upon rows of similar small houses, the occupants of which may be complete strangers to one another. There is neither community life nor inter-relationships and without these the herd is ill at ease. There is often no leader, human or divine, upon whom to lean.

In Industry

Neurosis and emotional illness are no respecters of persons. Russell Fraser's work on neuroses amongst factory workers published by H.M. Stationery Office in 1947 shows the high incidence amongst the random sample of industrial workers chosen—10 per cent. with severe disabling neuroses and a further 20 per cent. with minor forms of neurosis. He found that neurosis was the most frequent cause for absence from work and significantly exceeded even that caused by the common cold. So often so much of this form of illness (and do remember it has nothing to do with being weak-willed or that the patient can help being ill in this way, or even knows why he is ill) could be prevented if its nature was more widely understood and if, for example, there was in every industry a place where everyone from manager to employee could go and talk out his personal troubles or worries to an understanding and sympathetic doctor or nurse, psychologist or personnel manager.

Health visitors can concentrate on influencing mothers and families and parents together or in clubs or groups. They can also influence newly-weds, foster-parents and the staffs of children's homes, as well as those having the care of the old and the sick. With education, changes in the mental health of these people and groups would come slowly, but come they would, as surely as changes in physical hygiene were achieved in the past.

The Elderly

Finally, a word about the old people. They are becoming an increasing proportion of the population and the care of the elderly sick and infirm is becoming a sore tax on the hospital and other resources of this country. At present there are over five million people over 65 in this country; by 1980 it is estimated there will be between seven and eight million. Fortunately in the majority of cases the healthy and infirm elderly people remain independent or receive all the assistance they need from relatives or friends, but in present conditions with small families, small houses and little house room and most of the adults of both sexes going out to work, there is no one left to look after the old person should anything mental or physical occur to complicate or undermine his independent existence. Hence the large numbers seeking hospital admission and the desire, more frequent than was the case formerly, of relatives to have the aged remain in hospital or go to a welfare home or hostel.

The aim should be, as far as possible, to keep every old person at home as long as possible. They are best and happiest in their familiar homes and to be there, and to be treated there if possible, is in the actual interests of their mental health. Strange surroundings, such as a hospital, tend to make them confused and troublesome for a time. The health visitors and district nurses can do a lot to help; they can advise on what is best to be done and what services are available, whether hospital or local authority or voluntary organization; they may find solitary, independent old people very lonely and depressed and they may be able to help them considerably by encouraging them and even persuading them to join one or other of the clubs that cater for old people in most of our cities today.

To sum up: I recognize that what I have said is deficient in many ways. There is so much that could be said and had to be left out. I fear I have already tried to put more than a quart into a pint pot. I do believe, however, that it is only by preventive psychiatric knowledge exercised primarily through the agency of the public health service that the mental health problem can be greatly alleviated.

The Person All-Important

The magnitude of the problem is great and impact on it can only be made amongst the people in their homes or in small groups and through the normal agencies of the health service with the pivot of concentration on the home, starting, if possible, with the young married couple and going right through to the old age pensioner. Health visitors and nurses should be trained to think of all illness or disturbance as illness in a person, to see its emotional impact even if it is an organic illness like tuberculosis or cancer. If the *person*, starting with the baby, is all-important, then warm human relationships are established and this invites confidence and the outpouring of troubles. The skill of inviting rather than overtly seeking confidences will come with practice. Self-criticism and the evaluation of one's own attitude to other people, of one's effect on them and reaction to them, especially if they are obstinate or aggressive, is important. One must always try to make allowances, to *give*—tears, not anger are often the surprising result.

Preventive mental health starting in the home has its repercussions all through life. It is in the family and in the various clinics and with small groups that learning how to live with one another without friction can be taught, and it is from such humble beginnings that public education in the principles of mental health can be widely spread. It should be part of the training of all those whose professional work involves dealing with human beings.

* * *

Opening the discussion that followed, Mrs. Olwen Caradoc Evans welcomed the speaker's understanding of the problem which faced the health visitor in applying her knowledge to the mental health needs of the family. From her recent experience of life in a country district, she wondered if it was not easier for a rural than for an urban community to accept in its midst with harmony and tolerance the elderly and the mentally defective and to make allowance for their peculiarities. The field of mental health education offered much opportunity in the general community which was not yet recognized.

Speaking of her work in Cardiff as a health visitor specializing in the problem of mental health, Miss Jean Davies urged the need for fuller knowledge in order to be equipped for preventive work in the field of mental health. Such visits required more time to be spent in the home and demanded a good relationship with other colleagues in the health team.

Dr. W. Powell Phillips, deputy medical officer of health for Cardiff, agreeing with Dr. Hennelly's view that mothers of young children should not go out to work, felt this to be a matter that needed tackling at the political level in order to break the economic urge which sent such mothers out to earn.

Other speakers included Dr. W. E. Thomas, medical officer of health for Glamorgan, and Miss Nora Daniells, tutor to health visitor students, London County Council, who also proposed a vote of thanks to members of the Public Health Section within the Cardiff Branch at the conclusion of the meeting. The speaker and the chairman were thanked by Miss E. G. Wright and Miss Mary E. Davies, after which tea was served.

To commemorate the centenary of Florence Nightingale's Mission to the Crimea, we publish, in serial form, Sir Edward Cook's biography. This is the 18th instalment.

Florence Nightingale

The Government was far from niggardly in shipping stores and medical equipment to the theatre of war. But the lamentable fact was that these never arrived at the right place at the right time—if, indeed, at all. Fortunately, Miss Nightingale was able to make good the deficiencies, to some extent, from resources at her command; but she saw at once that it was the whole system of supplying the army and the military hospitals that was at fault—and she did not hesitate to report the fact to Mr. Sidney Herbert. Characteristically, however, Miss Nightingale accompanied trenchant criticisms of the existing procedure by practical suggestions for reform, both in organization and in medical matters—many of which were subsequently adopted by the authorities.

WE have seen at work the impelling power of a brain and a will; but with these, Florence Nightingale brought to her mission the tenderness of a woman's heart. She was the matron of a hospital no less than the mistress of a barrack. She was a resolute administrator, but to the sick and wounded among whom she lived and moved, and to the great public at home which heard of her work, it was the softer side of her character that made the more instant appeal. By them she was known and honoured not as the rigid disciplinarian or creative organizer, but as the compassionate and tender nurse. By them it was supposed that ministration to the sick, in the narrower sense, comprised all her work. But, in fact, as she wrote to Mr. Herbert (Jan. 14, 1855), nursing was "the least important of the functions into which she had been forced"; and those on the spot, who watched the arduousness of these other duties, wished that she could be persuaded to spare herself more of one kind of work or of the other. The marvel is that in unstinted measure she combined them both.

Busiest were the awful days on which fresh consignments of sick and wounded arrived from the Crimea. "Miss Nightingale has been known", said General Bentinck, "to pass eight hours on her knees dressing wounds and administering comfort." There were times when she stood for twenty hours at a stretch, apportioning quarters, distributing stores, directing the labours of her staff, or assisting at the painful operations where her presence might soothe or support.

"She had," said Mr. Osborne, "an utter disregard of contagion. I have known her spend hours over men dying of cholera or fever. The more awful to every sense, any particular case, especially if it was that of a dying man, the more certainly might her slight form be seen bending over him, administering to his ease by every means in her power, and seldom quitting his side till death released him." "We cannot," wrote Mr. Bracebridge to her uncle, Mr. Smith (Dec. 18, 1854), "prevent her self-sacrifice for the dying. She cannot delegate as we would wish; but the cases are so interesting and painful; who could leave them when once taken up?—boys and brave men dying who can be saved by nursing and proper diet."

It is recorded that on one occasion she saw five soldiers set aside as hopeless cases. The first duty of the overworked surgeons was with those whom there seemed to be more hope of saving. She asked to be given the care of the five men, and the surgeons consented. Assisted by one of her nurses, she tended the cases throughout the night, administering nourishment from her stores, and in the morning they were found to be in a fit condition for surgical treatment (*Daily News*, June 2, 1855). "Miss Nightingale," said a Chelsea pensioner, in recalling his experiences, "was always coming in and out. She used to attend to all the worst cases herself. Some of the new men were a bit shy at first, but many a time I've heard her say 'Never be ashamed of your wounds, my friend.'" "I believe", wrote a doctor, "that there was never a severe case of any kind that escaped her notice, and sometimes it was wonderful to see her at the bedside of a patient who had been admitted perhaps but an hour before, and of whose arrival one would hardly have supposed it possible she could be already cognisant."

Her days were always long; for she deemed it well not to allow any of her nurses to be in the wards after eight at night. And often, when all else was quiet, and she had been sitting up to finish her heavy correspondence, she would make a final tour of the wards.

A LAMP IN HER HAND

The description of these midnight vigils, given by Mr. Macdonald, the Commissioner of the *Times* Fund, became famous:

"... Her benignant presence is an influence for good comfort ... She is a 'ministering angel' without any exaggeration in these hospitals, and as her slender form glides quietly along each corridor, every poor fellow's face

A framed oil painting showing Florence Nightingale with Mr. and Mrs. Bracebridge awaiting the arrival of a convoy of wounded at Scutari. Presented by Mrs. E. Lovekin to the Florence Nightingale Hospital, N.W.1.

softens with gratitude at the sight of her. When all the medical officers have retired for the night and silence and darkness have settled down upon those miles of prostrate sick, she may be observed alone, with a little lamp in her hand, making her solitary rounds."

One poor fellow wrote home: "What a comfort it was to see her pass even. She would speak to one and nod and smile to as many more; but she could not do it to all, you know. We lay there by hundreds; but we could kiss her shadow as it fell, and lay our heads on the pillow again, content." "Before she came", said another soldier's letter, "there was cussin' and swearin', but after that it was as holy as a church."

The men idolised her. They kissed her shadow, and they saluted her as she passed down their wounded ranks. "If the Queen came for to die," said a soldier who lost a leg at the Alma, "they ought to make *her* queen." "She was wonderful", said another, "at cheering up any one who was a bit low." "She was all full of life and fun", said yet another, "when she talked to us, especially if a man was a bit down-hearted." And the magic of her power over men was felt, as Kinglake has described, "in the room—the dreaded, blood-stained room—where operations took place. There perhaps the maimed soldier might at first be craving death rather than meet the knife of the surgeon; but when such a one looked and saw that the honoured Lady-in-Chief was patiently standing beside him, and—with lips closely set and hands folded—decreeing herself to go through the pain of witnessing pain, he used to fall into the mood for obeying her silent command, and—finding support in her presence—bring himself to submit and endure."

A well-known member of Parliament, Mr. Augustus Stafford, went out during the recess of 1854 to Scutari, and made himself very useful to Miss Nightingale. "He says", wrote Monckton Milnes (Jan. 1855), "that Florence in the Hospital makes intelligible to him the Saints of the Middle Ages. If the soldiers were told that the roof had opened, and she had gone up palpably to Heaven, they would not be the least surprised. They quite believe she is in several places at once." They were impressed by her power, no less than they were touched by her tenderness, and ascribed to the Lady-in-Chief the gifts of leadership in the field. "If she were at their head, they would be in Sebastopol in a week", was a saying often heard in the hospital wards.

Miss Nightingale was careful to take note of any dying man's last wishes or messages, and the letters in which she forwarded these, to wife or mother, must, by their touch of womanly sympathy, have brought balm to many a stricken heart.

ALWAYS AT HER POST

The strain upon Miss Nightingale's physical and mental powers was incessant. Her health, as it proved in the end, was seriously impaired; but during all her work at Scutari, she was never absent from her post. "You had the best opportunities", she was asked by the Royal Commission of 1857, "for observing the condition of the soldier when he died and was sent to the cemeteries, when he was sent home as an invalid, and when he rejoined the army?" "Yes," she answered; "I was never out of the hospitals."

During the worst time of cholera and typhus, three of her nurses died, and seven of the army doctors. Miss Nightingale tended two of the doctors in their last moments, and the thinning, for a while, of the medical ranks increased her labours. The amount of clerical work which devolved upon her was enormous. The extent of the correspondence which she kept up with Ministers at home, with military and medical officers at the seat of war and at Scutari, is evident. Her superintendence of the nurses entailed another mass of correspondence; there were piles of store-keeping accounts and much correspondence referring to offers of help in money or in kind. That Miss Nightingale ultimately broke down under the strain was natural; the marvel is that she bore up against it so long.

She could not have coped with the mass of detail without a good deal of help. To Mr. Macdonald's assistance I have already referred; and like assistance was rendered for a time by the Rev. and Hon. Sydney Godolphin Osborne, the famous 'S. G. O.' of letters to the *Times*. Mr. Kinglake writes charmingly of "the enthusiastic young fellow who, abandoning his life of ease, pleasure, and luxury, went out, as he may have phrased it, to 'fag' for the Lady-in-Chief." The reference is probably to Mr. Percy, or possibly to Mr. William Shore, a distant relative of Miss Nightingale's father; he was put in charge of a soldiers' library. But it was Miss Nightingale's old friends, Mr. and Mrs. Bracebridge, who rendered the longest and most helpful aid. Mrs. Bracebridge shared alike her room and her labours, and with Mr. Bracebridge cared for the soldiers' wives. But Mr. Bracebridge did much else. Faithful, cheery and indefatigable, he fetched and carried for Miss Nightingale, wrote letters or orders for her, and kept minutes of her interviews, and sometimes relieved her of visitors or callers.

Miss Nightingale devised many practical ways of helping the men who were not too ill to think of their worldly affairs. In order to encourage them as much as possible to occupy themselves and to keep up a communication with home, she supplied stationery and postage stamps to those in hospital. If a soldier was illiterate or too ill to write, she or one of her nurses, or some other volunteer, would write at the sick man's dictation. Mr. Augustus Stafford, M.P., described to the Roebuck Committee the pitiable condition of the wounded on their arrival, "their thigh and shoulder bones perfectly red from rubbing against the deck" of the vessel which had brought them from the Crimea; but then Miss Nightingale's nurses came round, "and with a precision and rapidity which you would scarcely believe, would bring the soldiers arrowroot mixed with port wine, which was the greatest comfort; the men expressed themselves very thankfully, and said that they felt themselves in heaven." But it was in writing letters for the soldiers that Mr. Stafford spent most of his time at Scutari.

Miss Nightingale was much touched by the men's appreciation of these attentions, and she was no less impressed by the conduct of the orderlies in the hospitals. To the Secretary of State she wrote "I must pay my tribute to the instinctive delicacy, the ready attention of orderlies and patients during all that dreadful period; for my sake they performed offices [necessitated by certain sanitary reforms] which they neither would have for the sake of discipline, nor for that of the importance to their own health, which they did not know; and never was there one word nor one look which a gentleman would not have used; and while paying this humble tribute to humble courtesy, the tears come into my eyes as I think how, amidst scenes of loathsome disease and death, there arose above it all the innate dignity, gentleness, and chivalry of the men (for never, surely, was chivalry so strikingly exemplified), shining in the midst of what must be considered as the lowest sinks of human misery, and preventing instinctively the use of one expression which could distress a gentlewoman."

Even in the lowest sinks of human misery there are chords which will respond to a sympathetic touch. It was the innate dignity of her bearing that struck everyone who saw Florence Nightingale; and, amidst those scenes of loathsome disease and death, she was herself "the sweet presence of a good diffused."

(to be continued)

FLORENCE NIGHTINGALE COMMEMORATION

Thanksgiving Service, St. Paul's Cathedral, May 12, at 6 p.m.

The National Council of Nurses of Great Britain and Northern Ireland announces that a limited number of seats have been set aside for individual nurses wishing to attend the Florence Nightingale National Commemoration Day service. A stamped addressed envelope should be enclosed with the application to the Secretary, 17, Portland Place, London, W.1.

THE COLLEGE COUNCIL MEETS

April 1954

PRESIDING at the April meeting of the Council of the Royal College of Nursing, Mrs. A. A. Woodman, M.B.E., chairman, welcomed Miss M. Macnaughton, matron, Stracathro Hospital, who had been invited to serve on the Council in place of Miss M. C. Cameron.

The Professional Association Committee had considered a number of matters which were brought to the Council for further consideration. These included the variations in regulations for the provision of hospitality (in hospital and local authority services) for official and personal guests; also discussed was the recent Ministry of Health circular HM (54) 24 which proposed enforcement of the Ministry of Health's earlier recommendation that only 'block advertising' for hospital staff should be used. The Council members considered that conditions varied to such a degree throughout the country that the enforcement of one particular system of advertising would not be likely to achieve the best results and they suggested that matrons with evidence of the effectiveness or otherwise of such advertising be invited to submit it. The position in Scotland was also discussed.

A request had been received from the Minister of National Insurance inviting the College to put forward their views or suggestions on the proposed quinquennial review of the National Insurance Scheme. The third and fourth amended drafts of the Draft Regulations under Section 1 of the Local Government Superannuation Act 1953 had also been received and considered.

Miss H. Dey, C.B.E., presented the audited accounts for the year. These were approved and will be published in the annual report. A grant of £20 had been made to a member through the Sick Nurses Fund.

The Education Committee reported on the very successful refresher course held recently for administrators and tutors in hospital and public health fields; also the forthcoming courses to be held at the Birmingham Centre of Nursing Education.

Scholarship awards were approved by the Council as follows:

Cowdray Scholarship of £200 for the Sister Tutor Course to Miss T. Swindells, trained at The Hospital for Sick Children, Great Ormond Street, and at Guy's Hospital.

Occupational Health Section Scholarship of £200 for the Industrial Nursing Course, to Miss D. Davies, trained at the Royal United Hospital, Bath.

Halifax Scholarship of £350 for the Nursing Administration (Hospital) Course, to Miss R. V. Woods, trained at the Royal Infirmary, Halifax.

National Entrance Test for Student Nurses

The Education Committee reported further on the correspondence with the Minister of Health on the question of an entrance test for candidates seeking to enter the nursing profession. A reply had been received from the Minister stating that he could not agree to the imposition, at the present time, of any uniform test on a national basis. He had no objection to hospital authorities making use of such tests or of other methods of selection as they thought fit but he knew of no particular type which he would feel justified in commending to all on a voluntary basis. He would, however, take an opportunity of making known his views on the subject of the selection of student nurses in a memorandum to hospital management committees and boards of governors at an early date. The Council were concerned at this continued rejection of a minimum national entrance standard for student nurses; they appreciated, however, the Minister's assurance that he would make known to hospital authorities his views on the desirability of careful selection of student nurses, and that he did not contemplate that the main source of supply of pupil assistant nurses should come from those who had failed to train as student nurses.

Miss Macnaughton presented the report of the Branches Standing Committee, of which she is chairman, and of the Founders Day celebrations in Cardiff, which had been greatly enjoyed and appreciated by a large number of members. (These events have been reported fully in the *Nursing Times* of April 10 and 24.) The resolutions sent forward to the Council from the Branch representatives meeting dealt with two important matters. The Glasgow Branch resolution with regard to open membership of the College for nurses on the special registers of the three statutory bodies of the United Kingdom had been carried, but by a small majority, to be sent forward for consideration by the Council. The Council members held a full discussion on the reasons given in support of the resolution and considered the implications. It was agreed that a memorandum clarifying the essential points and dealing with certain definite questions which some Branches had raised should be circulated to the Branches, and the subject placed on the agenda of the next meeting.

The Council were in complete sympathy with the two resolutions on sick pay and while realizing that proposals were before the Whitley Council, expressed their concern that conditions for nurses were less favourable than those for other staffs employed in the health service.

Public Health Nominations

The Public Health Section had made a number of suggestions in connection with the regulations for the training and examination of nursery nurses. The Council were interested in the proposals but referred the detailed suggestions back to the Section for further consideration. The Section had also suggested experimental arrangements during the reconsideration of the constitutions of the Sections which aroused interest and discussion. The Council approved the Section's proposal that, in the event of an invitation being received to give oral evidence to the Government Working Party inquiring into the function and training of health visitors, the following members should be the representatives: Mrs. A. A. Woodman, Chairman of Council; Miss E. M. Wearn, Chairman of the Central Sectional Committee; Miss D. K. Newington, Deputy Chairman, Central Sectional Committee; Miss N. K. Richards, health visitor tutor, Chiswick Polytechnic; and from Scotland Miss J. Armstrong, health visitor tutor, Glasgow, and Miss G. Pike, superintendent health visitor, Edinburgh.

Invitations to nominate members to serve on local authority health committees had been welcomed from the following authorities: London County Council Health Committee; London County Council Divisional Health Committees; Middlesex County Council; County Borough of Croydon; West Sussex County Council; and City of Lincoln. An invitation to nominate representatives to serve for the years 1954/1957 on the seven Divisional Home Nursing Voluntary Committees of the Central Council for District Nursing in London had also been received. It was agreed that Miss P. E. O'Connell, health visitor tutor, Southampton University, should be re-nominated to represent the College on the Training and Examination Committee of The Royal Sanitary Institute, and on the Central Council for Health Education, Miss D. K. Newington, deputy superintendent health visitor, Buckinghamshire County Council, should be re-nominated to represent the College.

The Scottish Board reported the very successful conference for trained nurses at St. Andrews in March (already reported in the *Nursing Times* of April 3 and 17). They were also pleased to note the interest already being shown in the ward sisters course to be held in September, and the refresher course for health visitors, school nurses and tuber-

culosis visitors to be held in Edinburgh in June.

The Scottish Board, while welcoming the excellent booklet *Law Notes for Nurses*, pointed out that certain details would not apply to nurses working in Scotland as Scottish law differed from that of England and Wales.

For the Committee for Northern Ireland, Miss M. H. Hudson was happy to report that negotiations with the Belfast Health Committee on behalf of five senior nursing officers on the payment of increased salary scales in accordance with the recommendations of Whitley Circular NMC No. 19, which had been in progress since 1952, had now been concluded satisfactorily; the increased scales would be paid with retrospective effect to February 1949.

The Northern Ireland Hospitals Authority had received a deputation from the Committee to discuss a directive issued by the Authority to all hospital management committees in which regulations with regard to charges made to non-resident nursing staff were laid down which did not comply with Whitley Council recommendations. After representations by the Committee and the Association of Hospital Matrons, the Authority agreed to redraft the circular incorporating the deputation's recommendations.

The Committee for Northern Ireland had received with great pleasure official information that H.R.H. Princess Alexandra would also be present, with H.R.H. the Duchess of Kent, at the official opening of the new premises on May 28, 1954. The ceremony would be broadcast—the commentary being given by a student nurse. It was also hoped that it would be televised in the week's newsreel.

Miss H. M. Downton gave the report of the Student Nurses' Association and outlined the interesting programme arranged for the Association's annual meeting to be held this year in Glasgow on May 28 (see page 486).

Miss L. G. Duff Grant was invited to tell the Council members of her recent visit to Turkey at the invitation of the Turkish Nurses' Association for their celebrations, on World Health Day, of the centenary of the arrival of Miss Nightingale in Scutari for her great work during the Crimean War. Miss Duff Grant gave a vivid description of the civic and professional celebrations and the great gathering in Taksin Square, Istanbul. In the Selimeye Barracks, a plaque had been unveiled by the Mayor of Istanbul and Miss Duff Grant had addressed the gathering and presented a statuette of Miss Nightingale (see photograph in last week's issue). She had also been able to attend the capping ceremony at the Red Crescent School of Nursing, of which Miss R. A. Hone, formerly a sister tutor at the Nightingale Training School, is director. Miss Duff Grant brought back greetings from the Turkish Nurses' Association and said she felt sure that her journey, as President of the National Council, had been appreciated by the nurses of Turkey.

The date of the next Council meeting is May 20.

Scottish Sister Tutors Discuss the New Syllabus

AN important stage was reached in the history of the Scottish Sister Tutor Section with the whole day regional meeting on Saturday, April 10; in the past few years it has become increasingly evident that a half-day session was too short a period. The meeting was held in the Western General Hospital, Crewe Road, Edinburgh, by courtesy of Miss E. I. O. Adamson, matron.

Miss I. G. McInroy, R.G.N., S.C.M., Diploma in Nursing, University of London, was in the chair and welcomed the large gathering of sister tutors from all parts of Scotland, with observers and representatives from the General Nursing Council for Scotland and the Scottish Board. The main items for consideration during the morning were: discussion on bedmaking at State examinations, methods of sterilization of equipment, and the revised General Nursing Council Syllabus—suggestions regarding any changes which may be necessary in the State examination papers to meet the requirements of the new syllabus.

Examination Problems

Much discussion took place on bedmaking at State examinations. In Scotland it has been the practice for one candidate to make a bed and with no live model. This has resulted in feelings of dissatisfaction on the part of candidates and examiners for some time. The general feeling of the meeting was of agreement that two nurses should make a bed at the preliminary State examination and that there should be a live model in the bed to enable the nurses to exhibit their ability in approach to the patient and handling the patient. [Two live models are requested at examination centres so there should be no difficulty.]

The vexed question of methods of sterilization of equipment showed the inconsistency of methods being taught and practised. The group were reminded that the teaching of bacteriologists is that five minutes' boiling time is sufficient to destroy all vegetative organisms; what length of time it takes to destroy spores by boiling is yet unknown but after the preliminary cleansing of equipment it was felt that the likelihood of spores being present was a remote one. It was agreed that a uniformity of teaching of methods of sterilization should be the aim and it would be advisable to follow the scientific findings of the Medical Research Council Memorandum (revised edition) published 1951.

Suggested changes in the examinations which would be appropriate as a result of the new syllabuses were discussed with a view to sending suggestions to the General Nursing Council and a number of proposals were made.

In Part 2 on *Principles and Practice of Nursing and First Aid*, it was appreciated that pupils must be prepared to answer any questions set from this section. It was felt however that it should be possible to frame questions in such a way as to include human relationships and the hospital as a unit. It was suggested that the paper might be a two-hour paper consisting of six questions, of which four should be answered.

The educational test devised in England had never been used in Scotland. It was the feeling of the members that a modified selection test would eliminate academically unsuitable candidates before they entered the preliminary training school and thus reduce the expense of such candidates entering upon State registration training.

Miss J. T. Locke, principal sister tutor, The Victoria Infirmary, Glasgow, spoke of the value of hospital education committees whose duty and responsibility it would be to steer nurse education in hospitals. Such committees, it was envisaged, might include the matron, principal tutor, tutor in the preliminary training school, a ward sister, a medical representative and perhaps representatives from the neighbouring university, school and the public health field.

The morning session was brought to a close with the chairman's observations that two Scottish nursing teams were taking part in nursing contests south of the Border. A team from Stracathro Hospital, Brechin, was entering for the practical part of the Marion Agnes Gullan Trophy nursing contest, while a team from Seafield Sick Children's Hospital, Ayr, had taken part in the nursing contest organized by the Northern Group, Association of British Paediatric Nurses.

The meeting adjourned for luncheon.

The New Syllabus

At the afternoon session the subject was *The Revised General Nursing Syllabus*. The key speakers were Dr. Donald Cameron, M.B., Ch.B., D.P.H., Research Fellow in Department of Public Health, University of Edinburgh, and Miss G. B. Carter, B.Sc.(Econ.), S.R.N., Diploma in Nursing, University of London, M.T.D., Boots Research Fellow in Nursing at the Department of Public Health, University of Edinburgh.

Miss I. McInroy, R.G.N., S.C.M., was in the chair and gave a brief résumé, before introducing the key speakers of the events leading up to the revised General Nursing Council Syllabus.

Two years ago a weekend refresher course for sister tutors was held at Drygrange Hotel, Melrose, and following deliberation a recommendation was submitted to the General Nursing Council for Scotland that the time had come to make changes in the syllabus. This recommendation was made through the proper channels and in turn the Sister Tutor Section was asked to submit suggestions for changes in the syllabus. A subcommittee of sister tutors representing various fields of nursing was set up to prepare and present the suggested changes. This committee worked for a year and in 1954 the revised syllabus was passed and printed by the General Nursing Council for Scotland. This new syllabus takes effect from May 1, 1954.

Dr. Cameron commented on the comprehensive nature of the new syllabus, referring to it as a strict guide for tutor and student. He felt the time had come in nursing history to realize the need for less strict separation of male and female nurses. He could see

(continued on page 489)

STUDENT NURSES' ASSOCIATION

News from Units

Northampton General Hospital

After a lapse of over two years a Student Nurses' Association Unit has been formed again at Northampton General Hospital. On Monday, April 12, our second meeting was enthusiastically attended by 16 members and about a dozen potential members. Among these latter we were glad to welcome Miss E. B. Y. Lui, who won the recent Case Study Competition in the *Nursing Times*.

During the evening it was decided that a drama and social club be formed. A secretary for each was appointed, and we hope to hold a film show and social evening in the near future.

If all members remain as enthusiastic about the Association as they are at the present moment, then it will indeed be a flourishing movement.

JOYCE C. PARKER.

St. Margaret's Hospital, Epping

This is only our second year as a Unit, but we feel encouraged by it. We began with only 20 members and no funds and ended the year with 43 members and over £8 credit, having given a free annual dance, with a band. We are now quite able to take our place with other training schools and as students can only do this *officially* through our Unit. Talks given to us by Miss Spalding and Miss Walsh helped to encourage membership greatly.

We were very sorry to lose our past matron, Miss Elizabeth Hardman, who is now matron of the Royal Free Hospital; we hope she will some day visit the training school which she founded. We were very glad to welcome Miss I. M. D. Higgins as our new matron and president and are very grateful to her and to all our administrative staff for the help and kind advice which they have given us. We now have a body of trained and student nurse representatives who meet matron at intervals to discuss any matters affecting us either on or off-duty. We decided against amalgamation with the hospital social club; we felt that our prime function was to be a professional organization and that a little competition is a good thing.

We much enjoyed our visits to the Annual General Meeting and Winter Reunion; in particular we enjoyed Miss Ottley's account of her visit to Brazil and the chance to talk with nurses from all parts of the British Isles. We have had very well attended film shows in the lecture room, on a wide variety of professional topics, also on travel; these have cost little and we hope that they may continue. Miss Williams, the supervisor of midwives in our area, gave us a delightful talk on public health and the work of a district nurse. We have also had a very interesting talk on the House of Commons. Some members have visited the Law Courts and the Old Bailey, and a party of us slept at the Lambeth Hospital on the eve of the Coronation—the procession of excited people with flags and bundles streaming to Westminster in the grey dawn is as much an indelible memory as the sight of the golden coach itself.

Unit funds have been raised by whist and beetle drives and competitions and an open-air bazaar one lovely July afternoon. There was a competition to guess the owners of photos—all taken under the age of five years; the best part was the guessing and comments. These funds enabled us to give some of our male tuberculosis patients a special film show—three films of their own choosing. We hope to help the patients in various ways next year, especially the aged and those with few to visit them. Our new committee gave a well-attended fancy dress dance on St. Patrick's night.

We hope next year to see a steady increase in membership and more inter-Unit activities, and also an active interest in all professional matters within our own training school.

R. M. HEWITT.

TO ALL UNITS

Annual General Meeting

Glasgow, May 27 and 28

Please see that applications for attendance of representatives at the Annual General Meeting are sent to Headquarters at the earliest possible moment, and in any case not later than *Friday, May 14.*

Florence Nightingale Centenary

All Catholic nurses are invited to attend a service at the Church of St. John of Jerusalem, Hospital of St. John and St. Elizabeth, 60, Grove End Road, London, N.W.8, on Monday, May 10, at 7.30 p.m. The sermon, preached by the Reverend Father Agnellus Andrew, O.F.M., will be followed by Solemn Benediction. Nearest Underground Station—St. John's Wood; buses 2, 13, 113 and 159. This hospital has been under the care of the Sisters of Mercy since it was founded in 1856 on their return from the Crimea, where they formed part of Florence Nightingale's 'Angel Band'.

Annual Meeting—Scotland

Thursday, May 27.

Afternoon: Special tour of the Three Lochs (including Loch Lomond and Loch Katrine) with high tea at Arrochar.

Friday, May 28.

10.30 a.m. Divine Service at Glasgow Cathedral, Glasgow Central. Address by the Rev. Neville Davidson, D.D., Minister of Glasgow Cathedral, Chaplain to the Queen in Scotland.

2.30 p.m. ANNUAL GENERAL MEETING, Stobhill General Hospital (by courtesy of the Board of Management).

Immediately after the Annual General Meeting, Professor Andrew Robb, D.Sc., Professor of Naval Architecture, Glasgow University, will speak on *Professional Ideals.*

Admission to the Annual General Meeting will be by production of a valid membership card only. No duplicates can be issued at the time of the meeting.

A view of Loch Lomond, one of the three lochs to be visited.

Appointments

Whiteley Village Hospital, Walton-on-Thames, Surrey

MISS IVY P. CHAPMAN, S.R.N., S.C.M., Registered Sister Tutor, Housekeeping Cert., H.V. Cert., took up her appointment as matron on April 1. Miss Chapman trained at St. Marylebone Hospital, London; East End Maternity Hospital; Battersea Polytechnic; Hertford County Hospital, and the National Health Society. After holding posts as staff nurse, ward sister, and sister tutor in her training school from 1926-36, she became sister tutor at Hertford County Hospital in 1937 and deputy matron at Whiteley Village Hospital in 1948.

Colonial Nursing Service

The following appointments have been made by Queen Elizabeth's Colonial Nursing Service.

First appointments. As nursing sisters—Miss B. Y. Bates, Miss S. M. Carlisle, Miss E. J. Tonkin, Northern Rhodesia; Miss M. H. Kilcoyne, Cyprus; Miss I. J. Stenhouse, Nyasaland; Miss B. Stokes, Nigeria. As health visitors—Miss G. L. C. Martin, Miss M. A. Roberts Federation of Malaya.

Solution to Home and Overseas Crossword No. 5

Across. 1. Straw. 5. Pupil. 7. Emancipated. 10. Tender-hearted. 11. Dream. 13. Under. 14. Hairdresser. 20. Permanent wave. 21. Towed. 22. Baton.

Down. 2. Romance. 3. Win. 4. Neither. 5. Pea. 6. Pleated. 8. Study. 9. Adore. 12. Maria. 13. Upset. 15. Arrow. 16. Reels. 17. Exact. 18. Spit. 19. Lean.

Prizewinners

A book to Miss A. Bullock, Point Clear, Nongthymmai, Shillong, Assam, India, and to Miss B. Watson, Old Guild House, Penshurst, Tonbridge, Kent.

Nursing School Prizegivings

Above: *successful nurses at BRADFORD ROYAL INFIRMARY where Mrs. Odette Churchill, G.C., M.B.E., Légion d'Honneur, presented the awards. Centre, third from left, are Miss C. M. Dickie, matron; Miss J. D. Waddington, silver medallist; Mrs. Churchill; Miss A. Brennan, gold medallist, and Miss Scott, sister tutor.*

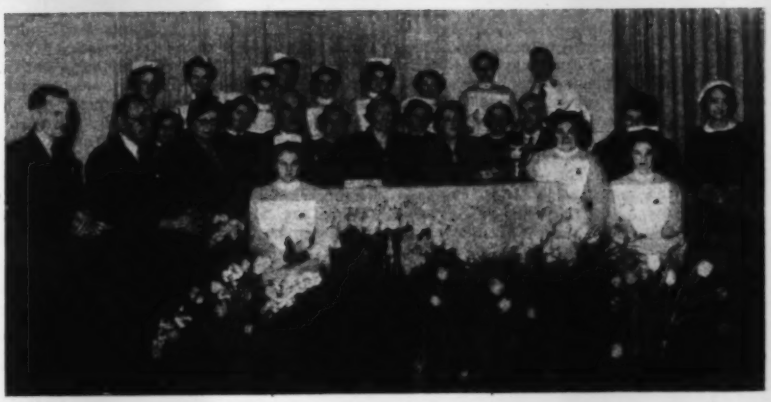
Above: *three prizewinners at the ROYAL BERKSHIRE HOSPITAL, Reading, where Sir William Penney, K.B.E., F.R.S., presented the prizes.*

Above: *at BIRMINGHAM GENERAL HOSPITAL the Rt. Rev. the Lord Bishop of Birmingham presents the gold medal to Miss Mary Ducrow. The silver medallist was Miss Peggy Blight and the bronze medallist Miss Elizabeth Morgan.*

Top: *Miss A. R. Spall, S.R.N., S.C.M., matron, with three prizewinners, after the ceremony at CLARE HALL HOSPITAL, South Mimms, where the awards were presented by Sir Fred Messer, M.P.*

Above: *after the first prizegiving to be held at ST. AUGUSTINE'S HOSPITAL, Chartham, near Canterbury. Awards were presented by Mrs. B. A. Bennett, O.B.E., Principal Nursing Officer, Ministry of Labour and National Service (centre right). With her are (right) Dr. C. E. A. Shepherd, (left) Alderman J. H. Johnson and Miss I. R. Taylor, matron.*

Right: *at MOORGATE GENERAL HOSPITAL, Rotherham, where the Countess of Scarbrough presented the prizes. In the group are Mr. A. R. Martin, O.B.E., and Miss C. Hall, matron.*



Royal College of Nursing

Public Health Section

Public Health Section within the Croydon Branch.—A meeting will be held at Mayday Hospital on **Wednesday, May 5,** at 7.30 p.m., to be followed by a talk at 8 p.m. by Dr. T. P. Rees, of Warlingham Park Hospital, on *Modern Treatment of Mental Disorders.* Miss M. Robinson will be in the chair. We hope all Branch members will be present. *Travel:* from West Croydon buses 109, 190, 130 pass Mayday Road.

Public Health Section within the Liverpool Branch.—The annual outing will be to the Lake District on **May 15.** Tickets, 25s. (deposit 11s.). We leave Mann Island pierhead at 9.30 a.m. Applications should be made to the secretary by May 8.

Public Health Section within the North Western Metropolitan Branch.—A study evening will be held at Hammersmith Hospital, Ducane Road, on **Wednesday, May 5,** from 6.15 p.m. There will be a talk followed by a visit to the new deep X-ray department. All are welcome.

Ward and Departmental Sisters Section

Ward and Departmental Sisters Section within the North Western Metropolitan Branch.—It has been found necessary to postpone the general meeting advertised in the News Sheet for **May 6.** It will now take place **on May 25,** at the Grafton Sisters' Home, University College Hospital, Tottenham Court Road, at 7 p.m. Miss **Charley will be** the speaker.

Occupational Health Section

NEW OCCUPATIONAL HEALTH GROUP

An Occupational Health Group for members of the Royal College of Nursing has now been established in Newport, Mon. If any State-registered nurse engaged in occupational health nursing would like information about the Group would she please write to the secretary, **Mrs. E. M.** Voyle, S.R.N., 48, Barrack Hill, Newport, Mon.

North West London Group.—A meeting will be held at Red Cross House, 100, Brook Green, Hammersmith, on **Monday, May 24,** at 7 p.m.

Branch Notices

Ayrshire Branch.—The annual outing has been arranged for **Saturday, May 8.** Transport will leave Baptist Church, Ayr, at 2 p.m. for Portpatrick where a meal has been arranged at Portpatrick Hotel. The journey to Portpatrick is to be made via the coast route, returning via Newton Stewart and Girvan.

Birmingham and Three Counties Branch.—*The Legal Position of the Nurse*—Student and trained nurses are invited to come to the meeting arranged at the Nurses' Home, Children's Hospital, Francis Road, on **May 6,** at 6.30 p.m. Speakers: Miss H. L. M. Gibbs, Barrister-at-Law; Miss Gaywood, an assistant secretary, Royal College of Nursing, who will speak on *The Work of the College.*

Bolton Branch.—A meeting open to all members of the nursing profession will be held at Bolton Royal Infirmary on **Wednesday, May 5,** at 7 p.m. Miss Gaywood, an assistant secretary of the College, will be speaking on *Whitley Council Conditions of Service for Nurses.*

Bradford Branch.—A general meeting will be held in the Nurses' Home, St. Luke's Hospital, on **Monday, May 3,** at 7 p.m. Agenda: to receive the report of the delegate to the Cardiff meetings.

Buckinghamshire Branch.—A business meeting will be held within the War Memorial Hospital, High Wycombe, on **Thursday, May 6,** at 6.30 p.m., preceded by an executive meeting at 6.15 p.m. A service to commemorate Florence Nightingale's Centenary will be held in the chapel of Tindal General Hospital on **Wednesday, May 12,** at 6.45 p.m., conducted by the Rev. H. Adeane Byard, Vicar of Aylesbury. Services are also arranged at the War Memorial Hospital, High Wycombe, and at the Amersham General Hospital on the same day.

Durham City and District Branch.—To commemorate the centenary of the departure of Florence Nightingale to the Crimea, a special service will be held in Durham Cathedral on her birthday, **May 12,** at 6 p.m. Members and their friends are invited to attend.

Gloucester Branch and Cheltenham Branch.—The Gloucester and Cheltenham Branches are holding a service in Gloucester Cathedral, to commemorate the centenary year of Florence Nightingale's departure to the Crimea, on **May 12** at 6 p.m. A collection will be made for the National Florence Nightingale Memorial, the object of which is to establish a permanent memorial for endowing Florence Nightingale House as an international hostel for nurses. There will be a special service for Catholic nurses in St. Peter's, London Road, Gloucester, on **Tuesday, May 11,** at 7.30 p.m. The service will include the Rosary and address on the work of Florence Nightingale and its application to the Catholic nurse today. Benediction.

Hastings and District Branch.—A general meeting, preceded by a view of handicrafts, will be held at Darvell Hall Sanatorium on **Thursday, May 6,** at 4.30 p.m. Miss Ward's report on the Branches Standing Committee meeting will be received. *Transport:* transport will be available at Bexhill Hospital at 2.15 p.m., Town Hall Square at 2.20 p.m., Royal East Sussex Hospital at 2.40 p.m., and The Buchanan Hospital at 2.45 p.m., returning at 5 p.m. Please send in requests not later than May 3. The evening service at Hastings Old Parish Church (St. Clement's) on **Sunday, May 9** at 6.30 p.m. will commemorate Florence Nightingale's birthday. The Rev. J. L. Napier has kindly arranged to reserve seats for those identified with the Royal College of Nursing.

Liverpool Branch.—The annual service for members of the nursing profession and their friends will be held in Liverpool Cathedral on **Sunday, May 9,** at 3 p.m. This year the Service will be a special one to commemorate the centenary of Miss Nightingale's work in the Crimea, and will follow the form of the commemoration service to be held in St. Paul's Cathedral. Preacher: the Right Rev. the Bishop of Liverpool.

North Western Metropolitan Branch.—The film of the Siamese twins operation will be shown at Hammersmith Hospital, Ducane Road, W.12, on **Thursday, May 6,** at 7 p.m., through the kind invitation of Miss Godden. Professor Ian Aird, Ch.M., F.R.C.S., will address members. Refreshments 1s. Will those wishing to attend inform the Branch Secretary, Room 496, Tavistock House South, Tavistock Square, W.C.1. (EUS 7175), by postcard or 'phone. Open to all members of the nursing profession. *Travel:* bus 7 from Oxford Circus to hospital gates; or Central London Line to White City, then 10 minutes' walk; or by trolley buses 628 or 630 from Hammersmith Broadway to Ducane Road.

Nottingham Branch.—A service to commemorate the work of Florence Nightingale and her band of nurses in the Crimea will be held in St. Mary's Church, Nottingham, on **Wednesday, May 12,** at 7 p.m. Address by Arnold Aldis, M.B., B.S., F.R.C.S. The collection will be devoted to the National Florence Nightingale Memorial Fund.

Redhill, Reigate and District Branch.—An executive meeting will be held at the East Surrey Hospital, Redhill, on **Tuesday, May 25,** at 3 p.m. A general meeting will be held at the East Surrey Hospital, Redhill, on **Thursday, May 27,** at 8.30 p.m.

South and West Somerset Branch.—A Florence Nightingale Centenary service will be held in St. Mary Magdalen Church, Taunton, on **May 12** at 6.30 p.m. All those interested in nursing are invited to attend.

Tunbridge Wells and District Branch.—Florence Nightingale National Commemoration Day: commemoration services have been arranged for **Wednesday, May 12,** at the Church of King Charles the Martyr, at 6 p.m. (by kind permission of the Vicar); preacher—Rev. R. W. Thornhill, Rural Dean; and at St. Augustine's Church at 8.30 p.m. (for Roman Catholics).

Worcester Branch.—The next meeting will be at the Royal Infirmary, Worcester, on **Monday, May 3,** at 6 p.m. We hope to have details of a bring-and-buy sale, to be held in June, in aid of the Educational Fund Appeal.

Yorkshire Branch at Leeds.—Florence Nightingale Commemoration Day: a service will be held in Leeds Parish Church on **Wednesday, May 12,** at 7 p.m. Evening Mass for Roman Catholics will be held in St. Anne's Cathedral on **May 13,** at 8 p.m.

Membership forms for the College may be obtained from the General Secretary, Royal College of Nursing, Henrietta Place, Cavendish Square, W.1, or local Branch Secretaries.

NURSES APPEAL COMMITTEE

Nation's Fund for Nurses

The Lenten offerings for the Nurses Appeal have been most gratefully received. We do appreciate the kind thought behind these valuable and generous donations. I would like to assure all those who have contributed that our older nurses who receive help in so many ways through these gifts are deeply grateful.

Contributions for week ending April 21

	£	s.	d.
College Member 30195		2	0
Lenten Offering (College Member 9343)	1	0	0
Central Middlesex Hospital	2	2	0
Matron and Sisters, Ramsgate Hospital	4	12	0
Miss W. A. Johnson	1	0	0
Miss S. Bellwood		5	0
Worthing Soroptomist Club	5	5	0
Dr. A. R. Friel	20	0	0
Her Grace the Duchess of Norfolk and the Worthing Branch	30	0	0
Princess Elizabeth Orthopaedic Hospital, Exeter:			
Children's Wards Lenten Savings	2		0
Nursing Staff	1	6	0
Total	**867**	**16**	**0**

W. SPICER, SECRETARY,
Nurses Appeal Committee, Royal College of Nursing, 1a, Henrietta Place, Cavendish Square, London, W.1.

SCOTTISH SISTER TUTORS DISCUSS THE NEW SYLLABUS

(continued from page 485)

no reason for special classes for male and female nurses studying genito-urinary subjects, and he questioned the title of the syllabus as a general one if it did not give the student a practical insight into the mental and tuberculosis fields.

Dr. Cameron then dealt with Sections I and II of the syllabus and he expressed the belief that the tutor was the person best suited to teach anatomy and physiology to student nurses. In dealing with Section II he felt the subject should be presented functionally, relating it to living and working conditions; the introduction to health and nutrition, Dr. Cameron felt, was most important and should be presented in some detail so that the nurse was introduced to her place in the Health Service. Two lectures on *Social Aspects of Disease* were not enough and the subject should be presented by a nurse in the public health field rather than by an almoner. The teaching of health should aim at making the nurse conscious of the prevention of disease and her part as a health teacher.

Miss G. B. Carter spoke next. She said: "Scotland is to be congratulated on the new syllabus." The attitude of 1919 was concern for the most part with people so entirely sick that they were detached, for the time being, from the stream of life, and in looking after this cloistered class the doctors and nurses were themselves apt to become cloistered in thought.

We now thought of the patient as a person with a past and a future, as well as with a present. The sister tutor and the others who trained nurses now regarded them as citizens, members of the community, preparing as citizens to serve other citizens, and this attitude was reflected in the syllabus.

Abraham Flexner had said in 1912 that medical education must be regarded as an *educational* problem rather than a *medical* problem, and this was equally true of *nursing* education. The aim in each training school or group of training schools should be to have an education department to which the tutors and other persons, whether ward sisters, doctors, public health nurses, or others taking part in the training of the student, should belong.

Many tutors would have to re-educate themselves in the modern attitude to patient care and keeping up-to-date could best be done on a co-operative basis, through, perhaps, a study circle. Various members of the staff could make themselves responsible for watching the newspapers, reading Government papers, reviews of books, new books, etc., and could then pool their knowledge, thus covering a wider field.

Practical points in connection with the new syllabus suggested by Miss Carter included pasting up the old and the new syllabuses, side by side, as in preparing a new edition of a book. Making the syllabus alive was also important; the imagination of students had to be stimulated on such subjects as housing, etc. simply became one more textbook idea. If they were encouraged to look at the floor space (bedrooms), toilet facilities, etc., thought necessary for the nurses' home, they could then visit with a 'seeing eye' the homes of the patients.

Role-playing was comparatively new in this country in the teaching of adults, but it was a very good way of stimulating the imagination of the student (and the teacher) and bringing the material from the pages of the textbook into real life.

"Teachers", said Miss Carter, "should read as widely as possible. From the point of view of making the training of nurses a true educational activity, Whitehead's *Aims of Education* and the books of Sir Richard Livingstone are among the best—*Education for the Future* and *Education for a World Adrift*." Other suggestions for reading included the annual reports of the Department of Health for Scotland and the Scottish Health Service Council; the annual report of the Health Department of the Burgh or County which the hospital serves; *Royal Commission on Scottish Affairs*, vol I. (which gives an account of Scottish Departments); *A Handbook on Scottish Administration* (H.M.S.O.); *Whitaker's Almanack* (annual, complete edition) (legal notes mention the Scottish law on adoption, illegitimacy, etc.); *The National Health Service in Great Britain (1952)*, by James Stirling Ross; and *The Dawn of Scottish Social History*, by T. Ferguson.

Discussion

In the discussion which followed the members exhibited agreement with the following points:

1. Education committees in every hospital are desirable. (There are few in Scotland.)

2. We should work for a more comprehensive training for the nurse, thereby providing her with a wider practical experience to give her a better preparation for her future responsibilities.

3. The tutor is the most suitable person to present anatomy and physiology to the student nurses.

4. The social aspect of disease should be stressed and the public health nurse should be asked to give the students their insight into this field.

5. The education of the nurse should be approached with wider vision, preparing her to be a good nurse and good citizen.

The meeting was closed with a vote of thanks to the speakers ably proposed by Miss Caie, principal sister tutor, Royal Infirmary, Aberdeen. In her vote of thanks Miss Caie indeed summed up the day's deliberations and referred to the need for a wider basic training, a point which had been brought out by Dr. Cameron. In reminding them of the transitional and revolutionary period through which nursing history was passing at the moment, Miss Carter had advised them to have courage to go on and for this good advice they feel indebted to her.

Miss R. H. Pecker, Registrar, General Nursing Council for Scotland, proposed a vote of thanks to Miss McInroy for the very able way in which she had chaired the meetings and had steered them through a very full day.

The members were asked to join Miss Adamson and her staff at tea, and before dispersing, Mrs. McDonald, principal sister tutor, preliminary training school, Dundee Royal Infirmary, proposed a vote of thanks to Miss Adamson and her staff for the very generous hospitality we had enjoyed in the course of a memorable day. A.I.C.B.

MRS. E. O. JACKSON

There will be a memorial service for Mrs. E. O. Jackson, R.R.C., at All Souls, Langham Place, London, W.1, on Monday, May 3, at 2 p.m.

Coming Events

Pendlebury Nurses' League.—The annual meeting and reunion will be held at the Royal Manchester Children's Hospital, Pendlebury, on Saturday, May 8, at 3 p.m.

The Catholic Nurses' Guild of Great Britain (Birmingham Branch).—In connection with the Florence Nightingale Centenary, solemn pontifical high mass will be sung by His Lordship Bishop Bright in St. Chad's Cathedral, Bath Street, Birmingham, on Wednesday, May 12, at 6 p.m. The Rev. J. O'Hear, M.B., Ch.B., will preach.

The National Hospitals for Nervous Diseases.—Mr. Murray A. Falconer will lecture on *The Surgical Aspects of Temporal Lobe Epilepsy* (in the series of lectures to be held at the National Hospital, Queen Square, London, W.C.1) on May 3 at 3 p.m. On May 6 at 2 p.m. Dr. P. H. Sandifer will lecture on *Infantile Cerebral Palsy*. An invitation is extended to all senior nurses. Kindly notify sister tutor if you intend to be present.

The National Society of Children's Nurseries.—A conference on *The Needs of the Family in a Changing Society* will be held at County Hall, Westminster Bridge, London, S.E.1, on Friday, May 7, at 10.30 a.m. Chairman: Edwin Ainscow, M.A., Children's Officer, London County Council. Speakers: Professor Fraser Brockington, Professor of Social and Preventive Medicine, Manchester University; Alice Stewart, M.D., F.R.C.P., Physician, Paddington Green Children's Hospital.

Miss W. McAllister, M.B.E.

Dame Beryl Oliver, D.B.E., R.R.C., Director of Education, British Red Cross Society, writes:

"It was 40 years since Winifred McAllister first came forward as a V.A.D. nursing member and since then she had worked continuously and selflessly. As matron of the Arthur Stanley Institute of The Middlesex Hospital, a member of the Council of the Chartered Society of Physiotherapy, a member of the Royal College of Nursing, of the Council of the Cowdray Club, and of the Archway Group Hospital Management Committee, Miss McAllister gave to all distinguished service.

Miss McAllister served throughout the First World War at Ingham Old Hall V.A.D. Auxiliary Hospital, Stalham, Norfolk and was Mentioned in Despatches and received the British Red Cross War Service Medal. She was awarded a V.A.D. Scholarship by the Joint War Committee of the British Red Cross Society and Order of St. John to undergo training as a physiotherapist at St. Thomas' Hospital, where she also trained as a State-registered nurse. She was then appointed massage sister at Parkwood Convalescent Home, Swanley. In 1928 when the British Red Cross Society opened the Clinic for Rheumatic Diseases in Peto Place, Marylebone, Miss McAllister was appointed matron and held that office until her death.

Her quiet serenity of manner endeared her alike to the staff and patients of the Institute and to many others with whom she had contact in her professional life. She never lost her freshness of outlook and enthusiasm and was constantly thinking of fresh ways of increasing the efficiency of the Institute in respect of staff and equipment. Miss McAllister will never be forgotten by those who knew her and worked with her, and the British Red Cross Society looks back on her work with gratitude and pride."